Erie Family Dentistry
77 Erie Village Square Ste. 200
Erie, CO 80516

PATIENT AUTHORIZATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

- Conduct, plan, and direct my treatment and follow up among that multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physicians certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complex description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at this time, except to the extent that you have taken action relying in this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: _____________

INSURANCE AUTHORIZATION

I hereby authorize Erie Family Dentistry, P.C. to affix my name to all insurance submissions, documents and/or all information requested by my insurance company relating to any and all dental benefits due to me and my dependents.

I agree and understand that full payment is required at the time service is rendered unless financial arrangements have been made.

I also authorize all insurance payments to be sent directly to Erie Family Dentistry. I agree to be held responsible for all charges and services not paid to Erie Family Dentistry by my insurance company.

I understand that Erie Family Dentistry, P.C. is a participating provider for MetLife, Cigna, and Delta Premier. With all other insurance plans, I understand that Erie Family Dentistry, P.C. is treated as an “Out of Network Provider.” I understand that it is my responsibility to understand my individual policy and how it pertains to “Out of Network Providers.”Erie Family Dentistry, P.C. is not responsible for changes and services not paid by my insurance policy.

Signature of Patient: ____

A photocopy of this authorization may act as an original copy for insurance purposes.