Oak Grove Dentistry, LLC

Insurance
To avoid any misunderstanding regarding dental insurance, we wish our patients to know all professional services rendered are charged directly to the patient or person responsible for payment of fees. As a courtesy to you, we will prepare reports or forms necessary to assist in obtaining benefits for you. We do not render services on the basis that insurance companies will pay our fees.

If you direct the insurance company to pay its share of the cost directly to our office, upon receipt of the insurance payment we will credit your account the amount and promptly refund the overpayment. Dental insurance was designed to be an aid in obtaining optimum dental health, it was not designed to be a “pay all.”

Authorization to Pay the Provider
I herby authorize payment directly to the above-named provider of the insurance benefits otherwise payable to me for the services described on the attached form.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES ON MY ACCOUNT.
A PHOTOCOPY OF THIS AUTHORIZTION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____

Name Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign this Acknowledgement

I have received a copy of this office’s Notice of Privacy Practices.

_____ _____

Signature Date

- Our Policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial agreement has been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your unpaid balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; for additional specialist consultation; or in the event I request my records to be transferred to another office.
- I understand the above information and guarantee this form is completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Signature Date