Beaches Endodontics
Robert T. Radel, DMD, MS

FINANCIAL AGREEMENT

_____ please initial INSURANCE ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Robert T. Radel all insurance benefits, for any services provided to me. I authorized any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, **I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.** I expressly agree and acknowledge that my signature on this document authorizes my physician/dentist to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim submitted.

_____ please initial Before treatment is started we will give our best **ESTIMATE** of what your portion will be, but insurance companies do not guarantee payment until the claim is processed. When we file your insurance we are extending you credit from your date of treatment. After 60 days if we have not received payment we will forward the unpaid balance to you for payment in full and you will then need to seek reimbursement from your insurance company.

_____ please initial Unpaid balances after 90 days will be assessed a **late payment penalty** at a 10% monthly finance charge. This will accrue until the account balance is paid in full.

_____ please initial I give consent for invoices to be emailed to the following address: _____

By signing below you acknowledge that you have read the above and understand that you are financially responsible for any unpaid balance for services provided. You understand that you are responsible for any collections or attorney's fees associated with the collection of any unpaid balances.

Patient (or Parent/Guardian) Signature:	Patient (or Parent/Guardian) Printed Name:	Date

HIPAA STATEMENT (You May Refuse To Sign This Portion of the Acknowledgement)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):
- Obtaining payment for third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

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

Patient (or Parent/Guardian) Signature	Patient (or Parent/Guardian) Printed Name	Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because: individual refused to sign, Communication barriers, emergency situation or other reasons.