ANDERSON DENTAL
SEDATION • SAME DAY • FAMILY

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.

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{Signature}

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{Date}

Signature on File Form

Subscriber Name______________________________

Subscriber Social Security Number______________________________

Primary Insurance Company______________________________

Address______________________________

Secondary Insurance Company______________________________

Address______________________________

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature authorizes my dentist to submit claims for benefits for services rendered or to be rendered without my signature on every claim submitted for myself or my dependants.

Authorized signature of covered person______________________________

The undersigned authorizes payment directly to Dr. Charles Anderson, Dr. Kathleen Anderson, or Dr. Patrick Anderson, also known as Anderson Dentistry, PLLC, benefits otherwise payable to him / her.

Authorized signature of covered person______________________________