Glen Lake Dental Associates, P.A.
Patient Authorization Form

PHONE COMMUNICATION (OPTIONAL)
By completing this section, you are giving Glen Lake Dental Associates (hereto referred to as GLDA) permission to leave your scheduling, medical and billing information with the person you state below and/or on the answering machine/voicemail phone number you provide.

I authorize GLDA to leave information on this voicemail/answering machine number:

(___ ___ ____) ___ ___ ____- ___ ___ ___ ____, regarding:

____Scheduling Information
____Dental and Medical Information
____Billing Information

I authorize GLDA to leave information with the following person:

_____, _____ regarding:
(First Name, Last Name) (Relationship to Patient)

____Scheduling Information
____Dental and Medical Information
____Billing Information

HIPPA: HEALTH INSURANCE PORTABILITY ACCOUNT ABILITY ACT:
The Health Insurance Portability and Accountability Act (HIPPA) afford you certain rights regarding the use and disclosure of your protected health information. Our Notice of Privacy Practices describes these rights in detail. GLDA has the right to revise this Notice of Privacy Practices at any time. You will be provided a copy of the revised Notice only upon your request.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT BILL OF RIGHTS:
As a patient of GLDA this policy outlines the rights afforded to me, as a patient. A copy was given to me.

MEDICAL AND DENTAL RECORDS:
I hereby authorize GLDA and its employees to release all medical, dental or financial information to all referring/treating physicians, insurers, or Medicaid Services or its agents, on behalf of myself and/or dependents.

ASSIGNMENT OF INSURANCE AND MEDICAID INFORMATION:
I hereby authorize assignment of benefits and payment of dental benefits to GLDA for services rendered to me and/or my dependents. I understand that GLDA reserves the right to refuse assignment of dental benefits. I agree to immediately forward all insurance payments that I receive to GLDA. I agree to be responsible for any balance due after insurance and/or charges not covered by my insurance policy. I hereby authorize GLDA to contact my insurance company directly to obtain coverage and payment information regarding my policy.

By signing below, I acknowledge that I have received information regarding, and agree with, the above. I understand these authorizations to be valid until revoked in writing.

_____ _____
Patient or Patient's Representative's signature Date