Virginia Dental Group, PLLC

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read **VIRGINIA DENTAL GROUP** Notice of Privacy Practices and that **a copy of such notice is available upon request.**

Initials_____

FINANCIAL AGREEMENT

I acknowledge that I have read **VIRGINIA DENTAL GROUP** Financial agreement and that by accepting treatment I agree with such agreement. I am aware that I am responsible for all fees of my treatment regardless of insurance coverage. I also acknowledge that I am responsible for any fees associated with the collection of my debt including but not limited to collection agencies and or any reasonable attorney fees. **A copy of the financial agreement is available upon request.**

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I have read and understood the form. I am signing this acknowledgement voluntarily. I authorize the disclosure of my health information as described in the AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION. **A copy of this authorization is available upon request**.

Initials_____

MEDICAL/DENTAL INSURANCE AUTHORIZATION SIGNATURE ON FILE

- ☑ I authorize use of this form on all my insurance submissions.
- ☑ I authorize release of information to all my insurance carriers.
- ☑ I understand that I am responsible for my bill.
- ☑ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier.
- ☑ I authorize payment directly to my doctor.
- ☑ I permit a copy of this authorization to be used in place of the original.

Initials_____

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Patient Name's (please print)

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Signature of patient or legal guardian **Date**

Lida M. Vargas, D.D.S.
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(Periodontist)

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