Diane L. Lide, DDS, PC

Frisco Pediatric Dentistry

INSURANCE AUTHORIZATION

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. Lide all insurance benefits otherwise payable to me. I understand that Dr. Lide remains a non-contracted, out-of-network provider to ensure that insurance companies do not attempt to dictate the treatment provided. Therefore, I am responsible for both payment of services rendered and any co-payment/deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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.

_____
Patient Name

_____
Guarantor Name

By signing below, I am acknowledging and agreeing to both the Insurance Authorization and Receipt of notice of Privacy Practices

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____