

**Financial Policy/Agreement and Assignment Information  
Authorization/Release of Medical Information**

**PATIENT NAME:** \_\_\_\_\_ **File #:** \_\_\_\_\_

**NOTICE TO OUR NEW PATIENTS:**

It is the policy of this office for patients to make payments (cash payments, co-payments, etc.) for services rendered prior to each visit. Other payment arrangements (ie. payment plans) must be specifically discussed and approved by this office prior to treatment initiation. X-rays taken in this office remain the property of this office. Initials \_\_\_\_\_

**ASSIGNMENT TO PAY BENEFITS TO PHYSICIAN:**

I hereby certify that I (or my dependent, parent, or guardian) assign payment and/or medical benefits, if any, otherwise payable to me for services rendered from this office, directly to this office. I understand I am personally and financially responsible for payment in full for all charges and expenses related to my treatment not covered by this assignment and as allowed by the insurance company as per the providers contract agreement. Initials \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION ACCORDING TO HIPAA:**

I hereby authorize the office of Max L. Denton, D.C. and Coleen A. Denton, D.C. to release any information acquired in the course of my examination and/or treatment in accordance to HIPAA (Health Insurance Portability and Accountability Act) guidelines. The release of information will include but not be limited to the processing of medical claims or information requested by insurance companies and/or other legal representatives after which proper authorization is received at this office. I understand and agree to the release of my health information as stated in the office policy which is in accordance to HIPAA guidelines. Initials \_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
(Patient or parent if a minor)

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_