CFD CENTREVILLE FAMILY DENTISTRY

Libby J. Thorpe DDS and Chad T. Thorpe DDS
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CERTIFICATION/AUTHORIZATION

I have reviewed the information on this form and certify that it is accurate and complete. If I have indicated I am not covered by dental insurance, I further certify that I am NOT covered by Medicaid, Healthy Kids, or MI CHILD.

I have read and understand the OFFICE AND FINANCIAL POLICY, and agree with all its provisions. I understand that it is MY responsibility to understand the terms of my dental insurance coverage. I understand that, as a courtesy, the dental practice of Chad T. Thorpe DDS, PLC makes reasonable efforts to anticipate patients' insurance coverage for procedures performed in this office; however, this office offers no guarantees for what insurance companies will ultimately pay. I understand that I am financially responsible for all charges not covered by insurance, and that my co-pay is due when services are rendered.

I authorize the insurance company(ies) indicated on this form to pay to Chad T. Thorpe DDS, PLC all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions for myself or minor children. I authorize Chad T. Thorpe DDS, PLC to release all information necessary to secure the payment of benefits for services rendered.

I agree to inform Chad T. Thorpe DDS, PLC on each visit if there is any change in my (my children's) insurance, before treatment is rendered.

I agree to inform the dental office on each visit if there is any change in my (my children's) medical/health status, including the taking of prescription and over-the-counter drugs, and supplements.

_____ _____

SIGNATURE (if not patient, state relationship to patient) DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1998 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your protected health information that we collect. Our full Notice of Privacy Practices is available in our office upon request. In summary, federal and state law allow us to release information without your explicit written permission in order to coordinate treatment with other healthcare providers, obtain payment for services we render, in connection with our healthcare operations, and under certain legal situations. You may give us written authorization to use your health information, or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time.

I, _____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.
(please print name)

_____ _____

SIGNATURE (if not patient, state relationship to patient) DATE

For office use: if this is not signed, please note that we attempted to obtain written acknowledgement of Receipt of our Notice of Privacy Practices, and reason we could not obtain acknowledgement:

_____ **Staff initials:** _____