Tony A. Piantek, DDS
115 Alpine Court
Shawano WI 54166

CREDIT POLICY & INSURANCE COVERAGE RELEASE NOTICE OF PRIVACY PRACTICES

Print Name _____

We are providing this payment guideline information to assist you in meeting your financial responsibilities for your dental care at our office.

~ Payments may be made in cash, by check or by credit card at time of service.

~ Payment is expected in full at time of service when there is no insurance coverage.

~ Insurance deductibles and co-payment are expected at time of service. We will file your insurance claims for you. Proof of insurance is required and will be verified.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting a portion of such charges.

The undersigned agrees to the above credit policy.

You may ask to receive a copy of our offices' s **Notice of Privacy Practices.**

To the extent permitted under applicable law, I authorize release of any information concerning my (or my child's) health care ,advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or specialist.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the treating dentist.

Signature _____Date _____