Michael Uss D.D.S
1024 Main Street, Onalaska, WI 5465

Consent for Use and Disclosure of Health Information

Assignment of Benefits

I hereby authorize payment of medical benefits to Smile With Uss Dental for the services described.

I give my permission to the doctor to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and/or my minor children.

I realize that I am responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles, non-covered services, etc.

Smile With Uss Dental Medical History

To the best of my knowledge, the questions on the form I filled out have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

HIPAA Notice of Privacy Practice

I acknowledge that I received a copy (or can obtain a copy) of Smile With Uss Dental Notice of Privacy Practices.

HIPAA Release

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION.AS DESCRIBED IN THIS FORM.

Acknowledgement of Assignment of Benefits

I acknowledge that I have received a copy of the Written Financial Policy (Assignment of Benefits) form, and agree to all of the terms and conditions described on the form.

By signing below I state that I have read and understand both the HIPPAA Notice of Privacy Practice HIPPA Release as well as the Assignment of Benefits. Additionally, by means of this signature, I affirm that I have filled out my Medical History as completely and accurately as possible.

Patient Name_____

Patient Signature_____ Date_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name_____