Your comfort. Our passion.

Office Policies/HIPAA

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

All fees are due at the time of service unless other arrangements have been made.

Every effort will be made to help me with my insurance, but if they do not pay as expected, I will be responsible.

By signing this form, you consent to our use and disclosure of your protected health information and to carry out treatment, payment activities, and healthcare educational operations.

I also understand that I have the right to revoke permission.

Patient/Parent/Guardian Signature: _____

Date: _____/_____/_____

Ted A. Beitelschees, D.D.S. · Glenn Fausz, D.D.S.

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