

**Sunseri Dental**  
9201 SE 91<sup>st</sup> Avenue, Suite 140  
Happy Valley, OR 97086  
(503)253-1344

## **Authorization and Disclosure (HIPAA)**

- CREDIT POLICY & FEES DISCLOSURE
- ASSIGNMENT OF INSURANCE BENEFITS
- AUTHORIZATION TO RELEASE INFORMATION
- FINANCIAL RESPONSIBILITY

**Truth In Lending Disclosure:** In accordance with the Federal Truth In Lending Act, we are providing the following information about our credit and fee policy:

1. Patient portion is due at the time of service.
2. Balances extended beyond 60 days from date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%).
3. There will be a \$50.00 fee charged per hour of Dental Hygiene time and \$50 per one-half hour of Doctor time for cancellations with less than 24-hour notice.
4. There will be a \$25.00 fee charged for all returned checks.

**Assignment of Insurance Benefits:** I hereby authorize Sunseri Dental to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to Sunseri Dental.

**Authorization to Release Information:** I authorize the 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.

**Financial Responsibility:** I understand that it is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the dental services received.

**Authorization to Perform Procedures:** I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

**Authorization to Transfer Records:** I authorize Sunseri Dental to transfer records when necessary on my behalf.

**I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.**

**I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.**

\_\_\_\_\_  
**Print Full Name**

(Patient or Responsible Person, if patient is a minor)

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Today's Date**

**Authorization valid until specifically revoked in writing**