Towne Pointe Dental

Acknowledgement of Dental record Portability
&
Financial responsibility

I authorize Towne Pointe Dental to release any information including diagnosis and the records of any treatments or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health care practitioners.

I authorized and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I also understand that the deductable is an estimation provided by Towne Pointe Dental staff, and my insurance estimation. I understand that such estimated copay and deductible is expected to be paid in full on the day when the service is provided and completed.

X _____ _____

Signature of patient or parents if minor Date