Springfield• Rolla• Osage Beach• Mountain Grove
1-877-Dentist • accessdentalanddentures.com

Notice of Privacy Practices

The Doctors and staff at Access Dental & Dentures understand that your medical information is personal and we are committed to protecting it. We create a record of the care and service you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. The Notice of Privacy Practices will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. You may request to read this notice or waive the offer and know that this information is available to you at any time during regular office hours. If you choose to read the Privacy Practices Notice, please review it carefully. By signing below, you are stating that you understand your rights and have read the options listed above.

_______________________________________ _______________________________
Patient /Guardian Signature Date

Authorized Parties

At Access Dental & Dentures, confidentiality of our patients is very important to us. Unless otherwise noted, we will not share any aspect of your health or financial information with any family members or friends. If you would like for certain family members/friends to obtain this information, please list them below and indicate the type of information authorized.

_________________________________ _____________________________ ○ Health ○ Financial
Authorized Party's Name Relationship

_________________________________ _____________________________ ○ Health ○ Financial
Authorized Party's Name Relationship

_________________________________ _____________________________ ○ Health ○ Financial
Authorized Party's Name Relationship

Assignment of Benefits

With your permission we will file your insurance claims for you. Please read the following statement and sign below giving us your permission. If you choose not to sign or would prefer to handle the insurance yourself, we require payment in full at the time of service.

I hereby understand that the fees that are listed in this claim may not be covered by or may indeed exceed all of my plan benefits. I also understand that I alone am financially responsible to the service provider for all of the cost that is associated with this claim and I do hereby assign my benefits payable from this claim to Access Dental & Denture and/or my service provider and I authorized payment directly to them.

I hereby certify that all of the information that is provided in connection with this claim is true, complete and accurate. I authorize any doctor, medical practitioner, or any other person that may have any records, knowledge or information regarding this claim to release such information and to exchange information with any of the named parties where the exchange is necessary for the proper processing of the claim. All photo copies of this signed Assignment of Benefits shall be as valid as the original.

_______________________________________ _______________________________
Patient /Guardian Signature Date