Nathan S. Darling, D.D.S.
7161 N. Port Washington Rd
Glendale, WI 53217
414-247-1470

Name: ___________________________________ Date: ____________________

Please read and initial:

____ Copays/Deductibles are expected at the time service is rendered. While we make every effort to determine the accurate amount of a copay, sometimes exact information is unavailable from the insurance carrier. In the event that a copay was underestimated or calculated incorrectly, the patient will be responsible for payment of the correct/adjusted balance due.

____ For direct-bill insurance plans, I hereby authorize payment of benefits directly to Darling Dental LLC for services rendered. I authorize release of any medical information that may be required in determination of such benefits.

____ I acknowledge that I may request a treatment plan estimate or pre-treatment estimate sent to my insurance.

____ I acknowledge that, in order to avoid a missed appointment fee, notice of TWO BUSINESS DAYS is required for canceling or changing an appointment.

____ I acknowledge that overdue accounts may be sent to a collections agency.

____ I acknowledge that I can choose to receive a copy of Darling Dental's "Notice of Privacy, HIPAA" Policy.

____ I authorize Darling Dental LLC to release my records and any information requested to the following individual(s). For example, your spouse, parent or anyone involved in your dental care, including appointment scheduling. Please print their name here:____

_____________________________ _____________________

Patient/Guarantor Signature Date

OR

_____________________________ _____________________

Parent/Guardian Signature Date