Kevin D. Clardy, D.D.S.
2221 Crockett Drive
Brownwood, TX 76801

ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I_______________________________________have been given access to this office's Notice of Privacy Practices.

____
Please Print Name

_________________________________ ___________
Signature Date

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my/my minor child's medical status. I authorize the dental staff to perform the necessary dental services for me/my minor child.

_________________________________ ___________________
Signature Date

RELEASE AND ASSIGNMENT

I certify that I/my minor child is covered by insurance with______________________________
Name of Insurance Company(ies)

And assign directly to Dr Kevin D. Clardy, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

_________________________________ ___________________
Signature of Patient/Parent /Guardian Date

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of my minor child. I accept full financial responsibility of all charges for services or items provided to me or the patient.

_________________________________ ___________________
Signature of Patient/Parent /Guardian Date