I hereby authorize **Twin Cranes Dental Group, PLLC** to release any applicable personal or medical information contained in my dental records for treatment, account balance resolution and other healthcare operations to appropriate agencies, including collection agencies, insurance agencies, insurance companies and third party payers.

Even though an insurance claim may be pending, I understand that I am responsible for all charges regardless of insurance coverage. I assign proceeds from insurance to **Twin Cranes Dental Group, PLLC** whenever applicable. I understand that I may receive statements each month when my account shows an outstanding balance.

I understand it is my responsibility to contact my insurance company to verify coverage, benefits and to obtain pre-authorization prior to services being rendered.

By signing below, I acknowledge that I have received a copy of the **Notice of Privacy Practices** and am aware that I can request a copy of the Notice at any time.

I certify that the above information I have provided is correct and that I have read and fully understand all sections of this form and affix my signature as patient or patient's legal representative.

***Patient/Legal Representative Signature (Responsible Party):**_____ **Date:** _____

Relationship to patient: _____

AUTHORIZATIONS:
I hereby authorize _____ **to:**

_____ Obtain information about scheduled appointments
INITIAL

_____ Discuss billing and financial arrangements
INITIAL

_____ Discuss my dental care
INITIAL