

# We're in the Business of Children's Smiles

www.CltPediatricDentistry.com

## Authorization for Release of Information To Family and/or Friends

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

David H. Moore, DDS, MS, PA is authorized to release protected health information about the named patient above to the following listed entities:

Entity Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Entity Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Entity Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Entity Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Entity Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please initial each situation giving David H. Moore, DDS, MS, PA your authorization to supply information to your entity.

\_\_\_\_ Leave information on the voice mail      \_\_\_\_ Give information to grandparent

\_\_\_\_ Release financial information      \_\_\_\_ Give information to spouse

\_\_\_\_ Give information to parent (patient is over 18 years of age)

\_\_\_\_ Give information to the following persons: \_\_\_\_\_

\_\_\_\_ Medical information as follows: \_\_\_\_\_

\_\_\_\_ Other information as described: \_\_\_\_\_

## Rights of the Patient

▪ I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to David H. Moore, DDS, MS, PA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

▪ I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

▪ I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

▪ This authorization shall be in effect until revoked by the patient or representative signing the authorization.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian/Personal Representative

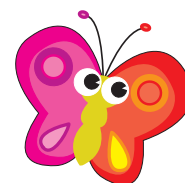
\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)



David H. Moore, DDS, MS, PA

Specialists in Pediatric  
Dentistry and Orthodontics



## OUR OFFICE LOCATIONS



### Cotswold/Midtown

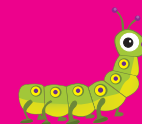
411 Billingsley Rd.  
Suite 106  
Charlotte, NC 28211  
Tel 704-377-3687  
Fax 704-377-9790

### University

10320 Mallard Creek Rd.  
Suite 150  
Charlotte, NC 28262  
Tel 704-547-8438  
Fax 704-547-9323

### Davidson

130 Harbour Place Dr.  
Suite 180  
Davidson, NC 28036  
Tel 704-896-8100  
Fax 704 896-8787



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## Financial Policy with HIPPA

Welcome to our practice! We recognize the importance of a relationship with your family founded on trust and communication. The following information will outline our office's financial policy. We welcome any questions you have and will do our best to answer them adequately.

## Payment Policy

Please be aware that the parent who brings the child to his or her appointment is legally responsible for the payment of all charges. This parent is responsible for payment of fees regardless of pre-existing custody agreements or court orders. As a fee-for-service practice, we require payment at each appointment for services rendered that day. We accept Visa, MasterCard, Discover, cash and personal checks. Additionally, a \$38.00 returned check fee will be assessed as applicable.

An insurance policy is a contract between you as a subscriber and the carrier of your insurance. Please be familiar with the benefits of your policy. For our patients with insurance, we will file your claims for you as a courtesy. Generally, the portion not covered by your insurance benefit is payable at the time of treatment unless a written estimate is obtained from your insurance company prior to the appointment. Our office does not file secondary insurance; however, we will gladly print a claim for you to file for reimbursement. We do NOT file Medicaid as a secondary. Signing this form constitutes authorization to release personal health information to insurance companies for reimbursement purposes.

Balances over 30 days are considered past due and may become subject to a 1.5% Finance Charge. If your account becomes past due, the account may be turned over to a collection agency. Any fees incurred due to collection process are your responsibility. We may be obligated to report your account status to any credit-reporting agency. If you have any questions concerning fees or regarding statements, please do not hesitate to ask our Account Coordinator.

## Appointment Policy

In consideration of our patients that are waiting to be scheduled, broken appointments or appointments cancelled without 24-hour notice may have a \$51.00 broken appointment charge assessed. Additionally, cancelled appointments without proper notice may necessitate in pre-payment of services prior to the visit being rescheduled.

If a pattern of broken or cancelled appointments persists, the patient may be placed on an inactive list to ensure that those patients committed to keeping appointments may be seen in a timely manner.

Child's Name \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



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