KRAUSE DENTAL
IMPLANT, COSMETIC, AND RESTORATIVE DENTISTRY

Authorization and Release:
I certify that I have read and understand all health questions given to me to the best of my knowledge. All health questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and for health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits, otherwise payable to me. I understand that any dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on any behalf or my dependents.

X_____ Date:_____
Signature of patient (or parent/guardian if minor)

PROFESSIONAL FEES AND PATIENT RESPONSIBILITY:

1. I understand that substantial time is reserved for each treatment session and that additional charges may be applied for tardiness, broken appointments, or cancelled appointments without at least 48 hours notice.
2. I understand that occasionally a tooth which has received dental treatment will require further treatment and if necessary any additional fee may be charged.
3. I understand that if I carry insurance and insurance does not pay, I am responsible for all balances, due within a 30 day period.
4. I understand that if my account should be turned over for legal collection, I agree to pay for all cost of collection including postage, court costs, and attorney fees.

_____ Date:_____
Please PRINT Name
X_____
Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the above office's Notice of Privacy Practices.

_____ Date: _____
Please PRINT Name

_____
Signature