KISKI ADVANCED DENTISTRY

1181 State Route 356
Leechburg, PA 15656
724-845-1041

Assignment of Benefits Form

I hereby assign all dental benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Dr. Todd Resek and Dr. Sean Bell for dental services rendered to myself and/or my dependents regardless of my insurance benefits if any. I understand that I am responsible for any amount not covered by insurance.

Authorization of Release Information

I hereby authorize Dr's. Resek and Bell to: (1) release any information necessary to insurance carriers regarding my treatment; (2) process insurance claims generated in the course of examination or treatment; (3) allow my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested dental services from Dr's. Resek and bell on behalf of myself and/or my dependents and understand that by making this request, I become fully responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred that my insurance does not cover, upon presentation of the appropriates statement. A photocopy of this assignment is to be considered as valid as the original.

Notice of Privacy Practice Acknowledgement (HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations, such as assessments and certifications

By signing this document, I also acknowledge that I can request your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime to obtain a current copy. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Responsible Party Signature_____ Date_____