

VALLEY BROOK FAMILY DENTAL
Assignment and Release

PATIENT: _____ **GUARDIAN / POA:** _____
(If patient is a minor or disabled)

I give my consent to Valley Brook Family Dental to provide ongoing dental care. I directly assign to Valley Brook Family Dental all dental 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 including electronic claims. I release Valley Brook Family Dental from all legal responsibility or liability that may arise from this authorization.

PEDIATRIC / ADOLESCENT CONSENT FORM

I give my consent to Valley Brook Family Dental to provide ongoing dental care to my dependent child or children. This consent will remain valid until revoked, or the patient reaches legal age of consent.

STATE INSURANCE COMMISSION RELEASE

I give my consent to Valley Brook Family Dental to provide the Pennsylvania Insurance Department (PID) with claim information containing personal health information for all claims that insurance carriers have not responded to within 30 days of submission. I also authorize my insurance company to release to the PID any medical/credit information pertinent to the resolution of my claim.

RELEASE OF INFORMATION

Valley Brook Family Dental will need your consent to discuss your care with anyone except yourself. If you wish to give us this permission, please list that person's name and relationship to you below:

Name: _____ Relationship: _____

Phone: _____ Address: _____

PATIENT ACKNOWLEDGEMENT: I have read and acknowledged the receipt of the above information regarding assignment of benefits, consent to treatment, and release of information.

Signature of Patient or Patient's Legal Guardian

Date