



HARBORVIEW  
ORAL + FACIAL SURGERY CENTER

Dr. Jason O. Rosetti

### Consent For Insurance Release

We are committed to protecting your confidentiality and right to privacy. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain consent from you prior to releasing any information to your insurance agency. If you desire for us to prepare your insurance claim and ready it for mailing for you, we need your consent. This will also permit us to respond to requests by your insurance company for explanation of treatment necessity or radiograph duplication and forwarding. Both are common requests by insurance companies necessary to complete claim processing and reimbursement.

Please understand this in no way allows for us to release any information regarding you or your treatment to any contractors, employers, government agencies, or any other third parties, except when stipulated by law. This is a strict statement regarding provision of information to your insurance company for processing your claim for reimbursement.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

### Insurance Information

Primary Insurance \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# \_\_\_\_\_  
Insured Name \_\_\_\_\_  
Insured SS# \_\_\_\_\_ Group # \_\_\_\_\_  
Insured DOB \_\_\_\_\_ Insured ID# \_\_\_\_\_  
Employer \_\_\_\_\_  
Is this  medical or  dental insurance?  
Insured's  
Relationship to Pt \_\_\_\_\_  
If patient is over 18, is patient a student? \_\_\_\_\_  
Where? \_\_\_\_\_

Primary Insurance \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# \_\_\_\_\_  
Insured Name \_\_\_\_\_  
Insured SS# \_\_\_\_\_ Group # \_\_\_\_\_  
Insured DOB \_\_\_\_\_ Insured ID# \_\_\_\_\_  
Employer \_\_\_\_\_  
Is this  medical or  dental insurance?  
Insured's  
Relationship to Pt \_\_\_\_\_  
If patient is over 18, is patient a student? \_\_\_\_\_  
Where? \_\_\_\_\_

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES INCURRED TODAY.  
I AGREE TO MAKE PAYMENT BY: ( \_\_\_\_ CASH), ( \_\_\_\_ CHARGE), ( \_\_\_\_ CHECK).

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

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I HEREBY AUTHORIZE PAYMENT OF BENEFITS TO DR. JASON O. ROSETTI FOR SERVICES PERFORMED THAT OTHERWISE WOULD HAVE BEEN PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT, INCLUDING ANY LEGAL FEES, IF INCURRED, TO COLLECT ANY OUTSTANDING BALANCE.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

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I UNDERSTAND THAT THE AMOUNT I AM PAYING TODAY IS AN ESTIMATE OF MY PORTION NOT COVERED BY INSURANCE AND THAT UPON PAYMENT OF THIS CLAIM A BALANCE MAY BE OWED BY ME AND WOULD BE PAYABLE AT THAT TIME.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*