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

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES INCURRED TODAY.
I AGREE TO MAKE PAYMENT BY: (_____CASH), (_____CHARGE), (_____CHECK).

_____   _____
Patient Signature   *Date*

. . . .

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*

. . . .

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*