



Patient Name: _____

DOB: _____

Authorization to file claim

I hereby authorize Dr. Richard Mounce, DDS, PC to file a claim for services to my insurance plan and/or any government agency for reimbursement. I request that Dr. Mounce furnish any and all information they may require from my record in order to process such a claim.

Signature: _____
patient or guardian / policy holder

Date: _____

Assignment of benefits

I hereby authorize payment of benefits from my insurance plan and/or any other government or private plan to be paid directly to Dr. Richard Mounce, DDS, PC, which will be credited to my account. I also understand that I am financially responsible for any amounts not covered by my insurance company including co-payments, co-insurance amounts, deductibles and any amount over the usual reasonable and customary guidelines.

Signature: _____
patient or guardian / policy holder

Date: _____

Notice of privacy practice (Hipa) receipt

Your signature indicates you have had the opportunity to request a copy of Dr. Richard Mounce's "Health Insurance Portability and Accountability Act" (HIPAA) notice.

Signature: _____
patient or guardian

Date: _____