Aesthetic Dental
DENTURES & IMPLANTS

340 Heald Way, Ste 218, The Villages, FL. 32163
Ph: (352) 633-2467 Fax: (352) 633-2157 www.AestheticDentures.com

1. Notice of Privacy Practices (must be signed by ALL new patients).

By signing below, I acknowledge that I have read Aesthetic Dentals' Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature_____ Date_____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below.)

2. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients)

By signing below, I agree to the terms of the Aesthetic Dental Patient Acknowledgements, Agreements, and Authorizations document

Signature_____ Date_____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below.)

3. Release of Information to Insurers and Assignment of Benefits (must be signed by ALL new patients with new insurance and those who expect to obtain insurance).

To the extent permitted by law, I consent Aesthetic Dental to use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Aesthetic Dental of the dental benefits otherwise payable to me.

Signature_____ Date_____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below.)

Responsible Party (if patient is under 18 or disabled)

Circle one: Dr/Mr/Mrs/Ms/Miss

First: _____Middle: _____Last: _____Jr/Sr: _____

Street: _____City: _____St: _____Zip: _____

Home Phone: _____Work: _____Cell: _____

Patient SSN: _____Patient Date of Birth: _____ Sex:(Circle) **M F**

Signature_____Date: _____