Dana Hodge King, D.D.S.

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San Antonio, TX 78209
210.829.7826
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AUTHORIZATION FOR INSURANCE: (if applicable)

The undersigned patient, in requesting examination and/or treatment, authorizes the release of all information (including x-rays) relating to that examination or treatment to health service plans and insurance companies. I hereby authorize payment directly to the dentist, the group insurance benefits otherwise payable to me, but not to extend the actual charges for the covered services. I understand that I am financially responsible for any charges NOT covered by the group insurance benefits.

Signature: **Date:**
Patient Name:

AUTHORIZATION FOR TREATMENT:

After having discussed treatment with the dentist, I grant authority to the dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary, to include any x-rays. The undersigned patient also authorizes the release of such information to any peer review committee of state and local dental associations, which may request it.

Signature: **Date:**
Patient Name:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I received and reviewed the office Privacy Policy Notice for Dana Hodge King, D.D.S.

Signature: **Date**:

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

In case you do not agree to sign this form, our office must indicate why you declined to do so.
Reason for refusal: