Belle Meade Family Dental
Dr. Jason Cox

Authorization and Release

- The above attached information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.
- I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Privacy Practices Acknowledgement

- I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Name Birthdate

_____ _____

Signature of Patient Date