Insurance Authorization Form
Episodes of Care
Authorization and Consent Upon Admission to the Community Dental Clinic

A. **CONSENT FOR TREATMENT**: I understand that my admission to the Community Dental Clinic is indicated because of my condition. I voluntarily authorize and consent to the customary initial examinations and tests required to assess any further treatments needed.
B. I, the undersigned, hereby authorize St. Joseph's Community Dental Clinic to release to my Third Party payor my protected health information and such diagnostic and therapeutic health information as may be necessary to determine benefit entitlement and to process claims for health care services given to me during my current treatment at the Clinic. I understand this authorization is valid only for the period of time necessary to actually process payment claims pertaining to me during this episode of care.
C. **AUTHORIZATION FOR RELEASE OF SOCIAL SECURITY NUMBER.** I consent to release of my social security number to the FDA or others as necessary for St. Joseph's Community Dental Clinic to comply with Federal Laws relating to medical device tracking.
By my signature below, I acknowledge understanding of the above statements A-C, that all my questions pertinent to these items have been answered to my satisfaction, that I have received or had access to my patient rights and formal grievance process information and that I provide such agreement, consent, authorizations and assignments.

PATIENT
Authorization for signature on File
Release of Information/Financial Responsibility

I, _____ hereby authorize Community Dental Clinic to affix my name to any and all claims or documents as related to any and all dental benefits due me.

I have reviewed the following treatment plan and fees. Minnesota Care may have a co-pay per each procedure applied to me. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law. I authorize release of any information relating to this claim.

This "Signature On File" will be valid from this date. A photocopy of this document may act as an original.

DOB:_____ Date: _____

Patient's Signature/Signature of Patient's Legal Representative: