**MCCUE DENTAL HEALTH**

**AUTHORIZATION AND RELEASE (Please read entirely before signing)**

**I hereby authorize Dr. McCue to release any information to third party payers**

**and/or health practitioners that is required for myself and/or my dependents.**

**If Insured:** **I authorize my insurance company to send payments directly to**

**Dr. McCue (benefits otherwise payable to me).** **I understand that my dental**

**insurance carrier may pay less than the actual fees for services rendered. I**

**agree to be responsible for payment in full, for all services rendered to myself**

**and/or my dependents.**

**I will also be held responsible for all charges involved in the pursuit of me or**

**my dependents past due account. I further understand that I am responsible**

**for any additional charges and collection fees, in the case of my account being**

**turned over to a third party for collection of a past due balance. All accounts**

**are subject to a 1.5% monthly interest rate on past due balances.**

**If I need to change or cancel any of my or my dependents appointments, I agree**

**to give Dr. McCue a 24 hour notice or risk incurring a failed appointment fee.**

**I also acknowledge that I received a copy of the Notice of Privacy Practices. (HIPAA)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGN ON THE LINE PLEASE**