**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)**

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**SIGN ON THE LINE PLEASE**