Patient Records Release Request

I authorize the release of my dental records to be sent out from the office of 425 Dental. I understand that there may be a duplication fee that is charged (in accordance with Section RCW 70.02, Medical Records).

Patient Name(s): _____ Date of Birth: _____

_____

_____

_____

_____

(additional family members w/ date of birth under age 18, if applicable)

Patient Signature: _____ Date: _____

I request that my records be:

☐ Released to me and I will be responsible for their delivery.

☐ Emailed to the dentist listed _____

I am having my records transferred for the following reason:

_____

_____

Where records are to be sent: (required information)

Name: _____

Email: _____ Phone: _____

Address: _____

Please email records to
info@425Dental.com

425 DENTAL

710 NW Juniper Street
Suite 101
Issaquah, WA 98027
www.425Dental.com

Office Policies & Notice of Privacy Practices

I authorize the release of my dental records to be sent out from the office of 425 Dental. I understand that there may be a duplication fee that is charged (in accordance with Section RCW 70.02, Medical Records).

Financial Policy

All patient portions will be due at the time of service. If you have insurance benefits, we will make a good faith estimate of your benefits and treatment costs with the information provided to us from your insurance company. As a courtesy, we will submit insurance claims on your behalf. If a claim is denied or payment is reduced for any reason by your insurance carrier, you will be responsible for the remaining balance on the account. Please keep in mind that your insurance coverage is a contract between the insurance company and your employer.

I acknowledge my responsibility for payment of the service received from 425 Dental in accordance with their regular fees and terms.

- I understand my responsibility is not modified by whether a third party (insurance) pays for: all, partial, or none of the charges.
- A finance charge of 1.0% per month may be accessed for any account which is not current or paid in full within 90 days from the date services were provided.

Assignment and Release

I authorize payment to be made directly to 425 Dental by my insurance company. Furthermore, I accept full financial responsibility for all services provided by 425 Dental, regardless of my dental insurance coverage. I authorize the release of any dental care information requested by my insurance company for the purpose of dental claim processing and/or payment.

Patient Name:_____

Patient Signature:_____

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