



Record Release Form

_____ hereby authorize
(patient's printed name)

(former dentist's name)

To provide South Berwick Dental with copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays, and all other records which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

As applicable, please send all records for the following persons for whom I am either the parent, guardian or POA.

Child Name: _____ Date of Birth: _____
Child Name: _____ Date of Birth: _____
Child Name: _____ Date of Birth: _____
Child Name: _____ Date of Birth: _____

Signed, _____
(patient)

Signed, _____
(patient, parent, legal guardian, or POA if patient is unable to sign for themselves)

Printed name _____
(patient, parent, legal guardian, or POA)

Date _____

Please mail or fax all records to:

South Berwick Dental

14 Highland Ave

So. Berwick, ME 03908

Tel. : (207)-384-2176

Fax : (207)-384-1981

Email : office@southberwickdental.net

South Berwick Dental

FINANCIAL POLICY

It is our primary goal to provide you with the best dental care. We know that sometimes the cost of treatment can prevent patients from receiving the treatment they want or need. Our team is here to help you navigate these financial barriers. We will make sure that you understand the fees associated with treatment, we will help you maximize your insurance benefits and we can help you with financing if/when needed. However, ultimately you are responsible for any fees incurred as clarified below.

We accept the following forms of payment: **Cash, Check, Major Credit Card, or CareCredit**

For Patients Without Dental Insurance:

Payment in full is due at the time service are rendered.

Although we do not offer in-house payment plans, we do offer third-party financing through CareCredit and we are more than happy to help you apply if desired.

For Patients With Dental Insurance:

In order to better assist you, please be sure to provide us with all of your insurance information. Also, please be sure to notify our office with any changes to your insurance coverage.

As a courtesy to our patients, we are happy to help you submit your dental claims to your primary insurance company. We will also **estimate** coverage at the time of your visit to determine any portion that will be due at the time services are rendered. This can be a deductible, co-pay or non-covered service.

Any portion left unpaid by insurance will be billed to you.

If there is a problem with your insurance claim or payment, we suggest that you contact your insurance carrier directly. Although we are always available to assist, the contract is between the insurance company and the insured.

*** Please note that all minors must be accompanied by a legal guardian**

I have read and agreed to the above policy,

Patient: _____ **Date:** _____

OR

Guardian: _____ **Date:** _____