DESIGNATION OF REPRESENTATIVE

FOR DISCLOSURE OF DENTAL, BILLING AND INSURANCE INFORMATION

Name of Patient: _____ Birth Date:_____

DESIGNATED REPRESENTATIVE(S):

NAME(S):_____

_____

RELATIONSHIP TO ME:_____

ADDRESS:_____

CITY, STATE, ZIP CODE:_____

PHONE NUMBER:_____

I designate the person(s) named above as my representative for all matters involving my dental care, billing coverage and benefits under any insurance benefit plan. This means I give North Shore Dental LLC permission to disclose and discuss any information it has or obtains about me, including confidential dental and medical information, with the named person(s). If the information held by North Shore Dental LLC includes information relating to mental health, alcohol and or drug abuse, this designation covers that information as well.

PURPOSE: I am requesting this designation so that the named person(s) can handle all questions and issues related to my dental services, billing, eligibility for coverage, plan benefits, payment of claims, preauthorization of treatment, and or appeals or grievances under any insurance policy. However, I may also contact North Shore Dental LLC, or the insurance company myself about any of these matters.

PERIOD COVERED: This designation authorizes North Shore Dental LLC, to disclose and discuss past, present and future information with the person(s) designated above for as long as I am covered under their insurance plan and as long as they are the responsible party for my dental services, unless I revoke this designation.

I understand that I have the right to withdraw this authorization at any time by providing a written withdrawal to the personal entity(s) disclosing my information. I am aware that my withdrawal is not effective until it is received and that it has no effect on uses or disclosures made prior to receipt of my withdrawal.

I understand that I am under no obligation to sign this designation and that I always have the option to talk directly to North Shore Dental LLC, my insurer's representatives and be responsible for my own bills to North Shore Dental LLC. I authorize North Shore Dental LLC to treat the person(s) designated above as my representative(s) as directed above.

Signature: _____ Date:_____

If individual is 18 or older and not signing, please state reason (i.e., disability or health condition) why individual cannot sign and signer's relationship to individual:

Permission to leave detailed messages on voicemail/ answering device _____ (Initial)

Please return the signed designation statement to the address below.