INTOWN DENTAL CENTER
QUALITY CARE YOUR FAMILY CAN TRUST

DO NOT BILL TO INSURANCE

Patient HIPAA Restriction Request

Election to Self-Pay for Services

[Section 13405 of Subtitle D of the HITECH Act (42 USC 17935)]

Please do not share the health information specified below to my health (Dental) Insurance company.

Specific service or test to be restricted: **ALL NON-COVERED, DISSALLOWED OR UPGRADED TREATMENT**

I acknowledge that I understand and agree that:

1. I am covered by a dental discount ("insurance") plan.
2. Despite the above, I do not wish Intown Dental Center to submit a claim to my insurance company for services provided to me by the office and thereby release the provider from the contractual obligations.
3. The dental service(s) provided, or that are to be provided, to me have been fully explained to me by my treating dentist.
4. I have freely chosen to self-pay for services after having asked the clinic about my payment options and having carefully considered those options.
5. I am aware that I may cancel this agreement at any time for future services.

I have read this election to self-pay for services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

Patient/Parent/Guardian Name: _____

Signature: _____ **Date**: _____

Intown Dental Center, 1250 Caroline Street, Suite C200, Atlanta, GA, 30307.

Web: www.intowndentist.com Email: jkearnsdds@intowndentist.com

Phone: (404) 889-8370, Fax: (404) 393-4893