Milford Dental Group

Anna Chisilenco Raho D.D.S.

Authorization to Pay Benefits and to Release Information

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been given a copy of the most current Notice of Privacy Practices provided by Milford Dental Group, Anna Chisilenco Raho D.D.S. for my review before signing this document. I am aware that copies of the Notice of Privacy Practices are available on line at mymilforddds@yahoo.com as well as in the office.

I have authorized payment to Milford Dental Group, Anna Chisilenco Raho D.D.S. for dental benefits otherwise payable to me as the subscriber in compliance with the insurance industry. I authorize this office to share my information with any insurance company, claims representative or consulting health care professional regarding my health care, recommendations for treatment, or materials provided. This information will be used for purpose of evaluating and administrating claims for benefits. This authorization is valid in accordance with the term of coverage of my insurance policy contract.

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Print Patient Name

_____ _____

Patient Signature Date Signature of Parent or Legal Guardian

Patient Consent to receive Mail, E-mail, Telephone Messages and/or Text Messages

I agree to allow Milford Dental Group, Anna Chisilenco D.D.S. to communicate with me electronically, by phone or by mail. I allow this office to mail, e-mail and/or leave messages on my phone numbers regarding confirmation of appointments, billing or dental information.

I consent to receive calls, text messages and e-mails related to my protected healthcare and other services from this office. I understand that I am responsible for any fees associated with wireless carriers or internet services.

_____ _____ _____

Phone Number E-mail address Postal address

_____ _____

Print Name Signature of Patient or Legal Guardian Date