The Hill Dental Group PLLC
8338 Spring Cypress Rd., Spring, TX 77379

Authorization and Consent to Release Information and Payment

I, _____, authorize The Hill Dental Group PLLC to release any information including but not limited to: records of examination, diagnosis and treatment rendered, referrals; to third party payers and/or other health care practitioners, dental professionals and labs in order to provide continuity of care.

I authorize and request my insurance to pay directly to
The Hill Dental Group PLLC, insurance benefits otherwise payable to me.

I understand that The Hill Dental Group PLLC is a private, fee for service practice and is not constrained by the limitation of insurance policies in determining what is best for me. In some instances my dental insurance carrier may not pay any or just a portion of the fee for my out of network services. I agree to be responsible for payment of all services rendered on the above named patient that are not covered or disallowed by my insurance company. _____

I consent to the making of photographs, videotape, x-rays and/or models from time to time, and to the use of same for the purpose of scientific papers and demonstrations.

I consent to being contacted for appointments or account information using the email address and/or text phone number given on the Patient Information Form.

I agree that The Hill Dental Group PLLC may communicate with me electronically.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling 281-376-0911.

Cancellations without a 24-hour notice and all No Show Appointments may be subject to a fee.

Date:_____

Signature of patient or parent if minor