Michael J. Bingham, D.D.S., P.A.
Specialist in Endodontics

Acknowledgement of privacy practice

I have been notified and agree with the privacy policies regarding HIPPA for Dr. Michael J. Bingham's office.

Print Name: _____

Signature: _____

Date: _____

Insurance release of benefits

I authorize Dr. Michael Bingham to bill my insurance for dental services performed by his office. I authorize payments to be made to their office and understand that I am responsible for any unpaid insurance amount.

As a courtesy we will be happy to verify benefits for you. Any information gathered from insurance company is an estimate only and not a guarantee of payment.

Print Name: _____

Signature: _____

Date: _____