Patient Request to Restrict Disclosure of Information

YOUR PRACTICE NAME (on practice letterhead)

Patient request to have no claim submitted to the insurance company for reimbursement, but rather to pay out-of-pocket for the treatment.

Today's Date: _____

Patient Name: _____ Date of Birth:_____

Address: _____

Street City State ZIP

I,_____ , request to pay in full (out-of-pocket) for the following dental services and that this treatment should not be submitted to my insurance company(ies) as listed below. I understand this request is made under the Patient Privacy Act.

Treatment: _____ Fee: _____

Treatment: _____ Fee: _____

Treatment: _____ Fee: _____

Treatment: _____ Fee: _____

Primary Insurance Company	**Secondary Insurance Company**
_____	_____
Name of Insurance Company	Name of Insurance Company
_____	_____
Subscriber (Patient)	Subscriber (Patient)
_____	_____
Group Number	Group Number
_____	_____
Patient/Legal Guardian Signature	Date

Warning: Sample Only – Contact your HIPAA Consultant and/or Healthcare Attorney for assistance regarding the proper use of this form in your practice.