

**Marty W. Lindahl, DDS, P.C.**  
**One Time Authorization Form**

**Patient Name:** \_\_\_\_\_

**WELCOME LETTER:** I have received a copy of the office welcome letter and acknowledge the appointment/cancellation policy.

Date \_\_\_\_\_ Initial \_\_\_\_\_

**MEDICAL CONSENT:** I require evaluation and/or treatment by a dentist and hereby consent to and ask for such care. This includes routine diagnostic work, and dental treatment that my dentist considers necessary. I acknowledge that no guarantees have been made to me regarding the outcome of examinations or treatment. I understand that I will not be involved in any research or experimental procedure without my knowledge or consent.

Date \_\_\_\_\_ Initial \_\_\_\_\_

**ASSUMPTION OF RESPONSIBILITY:** I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to Marty W. Lindahl, DDS, P.C. all charges for such services and incidentals incurred. Even though my insurance may be filed, I understand that all bills are payable upon receipt and that I and not the insurance company, am responsible for the payment of all services. In the event that an outside source for collection of fees becomes necessary, I will be responsible for all collection fees incurred.

Date \_\_\_\_\_ Initial \_\_\_\_\_

**ASSIGNMENT OF INSURANCE:** I hereby assign direct payment of any dental insurance benefits, or injury benefits payable because of liability of a third party or organization, and payable to or for the above said patient until account is paid in full.

Date \_\_\_\_\_ Initial \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:** I acknowledge receiving today a copy of Marty W. Lindahl, DDS, P.C.'s notice of privacy policies. I consent to the use of protected health information as described in the notice for treatment, payment, or health care operations.

Date \_\_\_\_\_ Initial \_\_\_\_\_

**PERMISSION FOR DISCLOSURE:** I give my permission to disclose my protected health information to the following people (list names and relationships—i.e. Jane Doe, Wife):

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

**Printed Name of Patient's Representative:** \_\_\_\_\_

**Relationship to the Patient:** \_\_\_\_\_