DO NOT BILL TO DENTAL INSURANCE

Patient HIPAA Restriction Request Election to Self-Pay for Services [Section 13405 of Subtitle D of the HITECH Act (42 USC 17935)]

Please do not share the health information specified below to my health (Dental) Insurance company. Specific service or test to be restricted: ALL NON-COVERED, DISSALLOWED OR UPGRADED TREATMENT

I acknowledge that I understand and agree that:

- **I am currently enrolled in a dental insurance plan that provides coverage for dental services.**
- **Despite my coverage, I choose not to submit a claim to my plan for services provided by this dental office. By doing so, I release the dental provider from any contractual obligations associated with my plan.**
- **My treating dentist has clearly explained the dental service(s) I am receiving, or will receive, to my full satisfaction.**
- **After discussing available payment options with the practice, I have made an informed decision to self-pay for my dental services.**
- **I understand that I may revoke this self-payment agreement for future services at any time. I have carefully reviewed this form, had the chance to ask any questions, and received responses that fully satisfy my concerns.**

Any questions I may have had about this form have been answered to my satisfaction.

Patient/Parent/Guardian Name: _____

Signature: _____

Date:_____