ARTHUR A. KEZIAN, DDS
NARINE TASHJIAN, DDS
443 N. Larchmont Blvd. L.A. 90004
(323) 467-2777

MICHAEL A. KEZIAN, DDS
581 N. Larchmont Blvd. L.A. 90004
(323)465-2127

GENERAL AUTHORIZATION FORM

Financial Responsibility: I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the service provider. I understand that I am responsible for all charges for services whether or not paid by insurance. I authorize the service provider to disclose all information necessary to verify my insurance eligibility and secure the payment of benefits.

Insurance Authorization Form: I consent to and authorize the indicated dental services to be performed and that any payments received from my insurance coverage will be credited to my account. I understand that Dr. Kezian/LDA accept all major Insurance companies and are Preferred Providers (PPO) with most Insurances, however, Dr. Kezian/LDA do not accept HMOs or certain PPO's, because the contracted fee reductions listed in some plan allowance schedules can significantly diminish the level of quality and care delivered and don't match to the standard of care that Dr. Kezian/LDA provide. Dr. Kezian/LDA are happy to determine Insurance eligibility and benefits, to submit treatment proposal for pre-authorization and process all the necessary Insurance claims on my behalf.

Medical Records: Dr. Kezian/Larchmont Dental Associates will be using electronic medical records, including radiographs, intra-oral pictures and my photograph, to maintain my health care information, and is committed to maintaining the privacy and confidentiality of patient health information (PHI) in compliance with HIPAA, and will only use my photograph for internal identification purposes.

Consent For Calls/Texts/Emails: By providing the number of my land line, cell phone or other wireless devices and my email address now or in the future, I expressly consent and agree that Dr. Kezian/Larchmont Dental Associates(LDA) office and any of its affiliates, agents, service providers or assignees may call me using an automated telephone dialing system or otherwise, leave me a voice message, or send me a text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with Dr. Kezian/LDA, or for other informational purposes related to my account or treatment ("Communication"). I also agree that Dr. Kezian/LDA and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. I agree that Dr. Kezian/LDA may monitor and record any telephone calls to assure the quality of its service or for other reasons.

Method of Payment:

☐ Payment in full at each appointment (Cash)

☐ Payment in full at each appointment (☐ Visa ☐ Master Card ☐ America Express ☐ Other)
Card#____ Exp. Date: ________________ CVV Code: __________

☐ I wish to discuss the Dental Office's Financial Policy including Care Credit and Credit Card

---

I have received the below listed items which relate to my dental care:

☐ California Dental Materials Fact Sheet (*Pink*)

☐ General Consent for Dental Work (*Yellow*)

☐ Dental Treatment Plan and Alternatives (*Green*)

☐ Visualization of Teeth and Fillings (*Booklet*)

____ ____________________
Patients Signature **Date**