PATIENT INSURANCE AND FINACIAL INFORMATION

PATIENT INFORMATION:

Patient Full Name: _____ ( ) Male ( ) Female

INSURANCE INFORMATION:

If you and/or your spouse have dental insurance, please bring the appropriate cards to your appointment. We are happy to submit your insurance without charge; however we do ask that you pay for your appointment at the time of service based on the below requirements. Your signature at the bottom of this document authorizes payment of benefits directly to Dr. Barnes and/or his associates.

AGREEMENT TO FINACIAL RESPONSIBILITY AND POLICIES:

The Federal Truth in Lending Act requires all doctors give their patients information in connection with extension of credit and payment expectations. Please be advised of the following policies, which apply to our office. The responsible party agrees to:

1) Pay at time of service unless there is a previous written agreement on all charges less than $200.00.
2) If payments extend beyond 90 days from the date of service there will be an 18% finance charge assessed monthly. I further agree to pay all legal and/or collection costs reasonably incurred in connection therewith. Interest not paid when due will be added to and become part of the principle balance.
3) A $40.00 charge will be assessed on all returned checks.
4) In the event my insurance company denies coverage for services rendered or does not make a payment with in 90 days, I agree to pay the balance in full, including any interest accrued.

IF PATIENT IS A MINOR:
I have legal authority to and hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment. In emergency situations I understand Dr. Barnes and/or his representatives will respond in the best interest of my child. By signing this agreement I am taking responsibility of account payment as ex-spouses/significant others are excluded to be held liable without written permission from said source.

MISSED/BROKEN APPOINTMENTS:

I understand there may be a $40.00 fee per hour, for appointments missed or rescheduled without 48 hours notice.

By signing below I consent that I have read and agree to the above financial terms in regard to my dental care.

_____ _____
Patient/Responsible Party Signature Date

Financial & HIPPA

Mark J. Barnes, D.D.S.
6700 Lookout Rd., Suite 1
Boulder, CO 80301

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14,2002).