PATIENT INFORMATION

LAST NAME FIRST M.I.

PREFERS TO BE CALLED ☐ Male ☐ Female

BIRTH DATE SOCIAL SECURITY NUMBER

SINGLE MARRIED PARTNERED DIVORCED WIDOWED

ADDRESS

CITY STATE ZIP

HOME PHONE NO.

EMAIL ADDRESS

CELL PHONE NO.

PREFERRED METHOD OF APPOINTMENT REMINDERS

☐ Phone call ☐ Text ☐ Email

HOW DID YOU HEAR ABOUT US?

EMPLOYER

OCCUPATION EMPLOYER'S NAME

ADDRESS CITY

WORK PHONE NO. FAX NO.

SPOUSE INFORMATION

NAME

OCCUPATION EMPLOYER'S NAME

ADDRESS CITY

CELL PHONE NO. WORK PHONE NO.

PERSON FINANCIALLY RESPONSIBLE

NAME RELATIONSHIP TO PATIENT

BIRTH DATE SOCIAL SECURITY NUMBER

ADDRESS

CITY STATE ZIP

HOME PHONE NO. CELL NO.

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

EMPLOYER NAME

INSURED'S NAME RELATIONSHIP TO PATIENT

BIRTH DATE INSURED'S SOCIAL SECURITY NUMBER

POLICY ID NO. POLICY GROUP NO.

INSURANCE COMPANY PHONE NO.

SECONDARY CARRIER

INSURANCE COMPANY

EMPLOYER NAME

INSURED'S NAME RELATIONSHIP TO PATIENT

BIRTH DATE INSURED'S SOCIAL SECURITY NUMBER

POLICY ID NO. POLICY GROUP NO.

INSURANCE COMPANY PHONE NO.

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) ___________________________________'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as deemed necessary and appropriate my care. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a full recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I hereby authorize payment directly to Denver Restorative Dentistry of the group insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that an 18% APR may be added to my account per month until balance is paid. If required, I also understand a check of my credit may be made. In the case of default of payment, I promise to pay any legal interest on the balance due, together with a collection fee of $35.00 and/or reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

6. I, _______________________________ agree that the information on this page is correct to the best of my knowledge.

_______________________________________ _________________________________ ______________

Patient or Responsible Party Signature | Relationship to Patient | Date

_______________________________________ _________________

Witness | Date

FINANCIAL POLICY

Please Initial

1. ***It is the patient's responsibility to ensure that any insurance information given to our office is correct and current.*** Failure to provide accurate information will result in patient financial responsibility for all services provided. If incorrect insurance information is provided and claims must be reprocessed, this may result in a re-processing fee being added to your account. This includes the omission of secondary insurance carrier. _________

2. ***It is the patient's responsibility to know his/her insurance coverage.*** In-office estimates are done as a courtesy to the patient, and are based on the coverage percentages given to Denver Restorative Dentistry by your insurance company. Denver Restorative Dentistry cannot be held liable for any stipulations or clauses in your plan which alter or adjust the estimated patient portion. We are always willing to submit pre-authorizations for proposed work at the request of our patients; however pre-authorizations are not a guarantee of payment by your insurance company. _________

3. ***Estimated out-of-pocket payments are to be paid at the time of service.*** Any remaining charges that are not covered, or charges that are denied by the patient's insurance plan must be paid within 30 days. A 5% finance fee will be added to past due balances. _________

4. All accounts that are 90 days past due will be sent to an outside collection agency with a $35.00 fee applied to your account in addition to any other finance fees that are incurred. _________

5. Any personal check returned to the office for insufficient funds will result in the account balance being re-established and a $25.00 service charge added to your account. All subsequent visits will need to be paid with cash, credit card, or other certified funds. _________

6. If the patient fails to cancel a scheduled appointment with this office at least 48 hours prior to the appointment, the patient may be charged a $100.00 fee for the missed appointment. It will not be billed to the patient's insurance and it will be the patient's personal responsibility. _________

I have read and understand the above policies.

____________________________	____________________
Patient or Responsible Party Signature	Date
____________________________	____________________
Patient's Name (printed)	Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Denver Restorative Dentistry to use and disclose my protected health information for the following purposes:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (i.e. insurance company).
- The day-to-day healthcare operations of the practice.

In addition, I authorize Denver Restorative Dentistry to disclose or speak about my protected health (i.e. dental care, test results, account, appointment and pre-medication reminders) with the following person(s):

1. ____
   Name Relationship

2. ____
   Name Relationship

Secondly, I authorize Denver Restorative Dentistry to leave details regarding my protected health information (i.e. dental care, test results, account, appointment and pre-medication reminders) on a voicemail at the following numbers:

1. ______________________________(work / cell / home)

2. ______________________________(work / cell / home)

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that the practice reserves the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Denver Restorative Dentistry is not required to agree to these requested restrictions. However, if Denver Restorative Dentistry does agree, the office is then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to this date I revoke, this consent is not affected.

______________________________________ ________________________
Patient Name (printed) Date

______________________________________ ________________________
Signature Relationship to Patient

8181 Arista Place Suite 140

Broomfield, CO 80021

Photography Release

I ________________________________, hereby authorize Denver Restorative

Dentistry and its employees the right to take photographs of me in connection with my dental procedures. I understand that **non-identifying** photos and/or videos can be used as a record of my care, may also be used for educational purposes in lectures, demonstrations, on event and business advertising (including website, social media, publication, newspapers, magazines, television), and in professional publications (dental magazines and journals).

I do not expect compensation, financial or otherwise for the use of these photographs.

________________________________ ________________________

Patient or Responsible Party Signature Date

________________________________ ________________________

Patient's Name (printed) Relationship to Patient