IMPORTANT QUESTIONS RELATING TO INSURANCE

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS:

TODAY'S DATE: _____

PATIENT NAME_____DOB_____

Please carefully read the following and sign

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change *its Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____ **Relationship to patient** _____

DO YOU HAVE **ORTHODONTIC** INSURANCE? YES____ NO____

NOTE: We are a Delta Dental provider **ONLY**. We are able to submit claims only to Delta Dental, they will send payment directly to us. If you have coverage through another plan, we will provide you with a claim form that you can submit to your insurance company. The insurance company will then reimburse you if a benefit is due to you according to your policy.

You as the patient or parent are ultimately responsible for any fees incurred at our practice. We are happy to work with you to maximize your orthodontic benefit.

If you have Dental/Orthodontic insurance please complete the following:

Name of Insurance Company: _____

Insurance Company address: _____

ID# _____ Group# _____

Subscriber name: _____ Subscriber birth date: _____

Subscriber address: _____

Subscriber relationship to patient: _____ Employer of subscriber: _____

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges and dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with claims. I authorize and direct payment of dental benefits otherwise payable to me, directly to Gregory L Baker, DDS.

Signature _____ **Relationship to patient** _____

For office use only:

CONSULT DATE:_____

CHART ☐ (Insurance Stickers)

TX **Sheet** _____ Ins. Co. on Tx sheet

Revised 11/17/11