FINANCIAL POLICY OF DR. DANIEL J. BARTON

THE FOLLOWING POLICY MUST BE READ AND SIGNED PRIOR TO SERVICES BEING RENDERED

PAYMENT:
PAYMENT FOR ALL SERVICES IS DUE AT THE TIME OF YOUR APPOINTMENT. OUR FRONT OFFICE STAFF IS COMMITTED TO GUIDING YOU IN CHOOSING THE BEST PAYMENT OPTION TO MEET YOUR INDIVIDUAL NEEDS. WE ACCEPT, VISA, MASTERCARD, DISCOVER, AM EX, CARE CREDIT, CASH, OR CHECK AS FORMS OF PAYMENT. IF YOU ARE UNABLE TO MAKE PAYMENT AT THE TIME OF YOUR APPOINTMENT, IT MAY BE NECESSARY TO RESCHEDULE YOUR APPOINTMENT FOR A TIME IN WHICH PAYMENT WILL BE MORE COMFORTABLE FOR YOU.

DENTAL INSURANCE:
I AUTHORIZE THE OFFICE OF DR. DANIEL BARTON TO RELEASE ANY PROTECTED HEALTH INFORMATION NECESSARY TO PROCESS MY DENTAL INSURANCE CLAIM. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. IF GIVEN THE CORRECT INSURANCE INFORMATION, OUR EXPERIENCED STAFF WILL FILE YOUR INSURANCE CLAIM ON YOUR BEHALF. IF YOUR INSURANCE HAS OUT OF NETWORK BENEFITS, PAYMENT FOR THESE SERVICES WILL BE REIMBURSED TO YOU.
IF THERE ARE QUESTIONS REGARDING THE PROCESSING OR PAYMENT OF YOUR DENTAL CLAIM, WE SUGGEST THAT YOU CONTACT YOUR INSURANCE COMPANY DIRECTLY. WE FILE INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS, BUT YOUR CLAIM IS STILL YOUR RESPONSIBILITY.

ACCOUNT COLLECTIONS:
IF IT BECOMES NECESSARY TO SEEK A COLLECTION AGENCY TO RECEIVE PAYMENT FROM YOU, YOUR ACCOUNT WILL BE CHARGED A FEE OF $25. IT WILL BE YOUR RESPONSIBILITY FOR ANY COSTS RELATED TO THE COLLECTION OF YOUR ACCOUNT.
THERE IS A $25 RETURN CHECK FEE FOR ANY CHECK THAT IS RETURNED TO US UNPAID.

TODAY'S EXPECTED TREATMENT: #_____

ESTIMATED FEE FOR SERVICE:_____ INITIAL RESPONSIBILITY:_____

MINOR PATIENTS: THE PARENT OR ADULT ACCOMPANYING A MINOR PATIENT TO THEIR APPOINTMENT IS RESPONSIBLE FOR ANY PAYMENT DUE AT THAT TIME. IF THE PATIENT IS A MINOR, PLEASE LIST YOUR NAME AND SS# HERE:
PARENT/GUARDIAN:_____ SS# OF PARENT/GUARDIAN: _____

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY AND MAY REQUEST A COPY OF THIS AGREEMENT.

SIGNATURE_____ DATE_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I GIVE YOUR OFFICE PERMISSION TO RELEASE DENTAL INFORMATION REGARDING MY TREATMENT AND ACCOUNT TO:
NAME:_____ RELATIONSHIP: _____
NAME:_____ RELATIONSHIP: _____
NAME:_____ RELATIONSHIP: _____

A COPY OF OUR PRIVACY PRACTICES ARE LOCATED IN OUR LOBBY. YOU MAY REQUEST A PRINTED COPY IF YOU PREFER. I HAVE READ OR RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE _____ DATE_____