Gregory B Waters DDS, PC
8850 Ralston Road, Suite 104
Arvada, CO 80002
Ph: 303-420-3233

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patient themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below.** You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of Dr. Gregory B Waters, DDS, on my behalf regarding (**please check all items authorized**).

Name of authorized person(s):_____ Relationship_____
Phone number_____
___Appointments ____Financial _____Dental Treatment ____Insurance ____Other (explain)

Name of authorized person(s):_____ Relationship_____
Phone number_____
___Appointments ____Financial _____Dental Treatment ____Insurance ____Other (explain)

Name of authorized person(s):_____ Relationship_____
Phone number_____
___Appointments ____Financial _____Dental Treatment ____Insurance ____Other (explain)

Authorization to Leave Health Information by Alternative Means
I authorize Gregory B Waters, DDS and staff to use the following telephone numbers provided on the Patient Registration Form to leave messages on voice mail for reminder calls and other patient matters.
____Home Phone ____Work Phone ____Cell Phone

____ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name:_____ Date of Birth_____
Please Print Name

_____ _____
Signature of patient or patient's authorized representative Date

ASSIGNMENT OF BENEFITS AGREEMENT
GREG WATERS, DDS

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.

- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an estimate of charges and may be found to be insufficient after review by your insurance company.

- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

_____

Print Name of Patient or Responsible Party

_____ _____

Signature of Patient or Responsible Party Date

GREGORY B. WATERS, DDS, PC
General Dentistry

8850 Ralston Road, #104
Arvada, CO 80002

(303)420-3233

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

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

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this 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 you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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

Signed this _____ day of _____, 20_____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

FINANCIAL AGREEMENT
GREG WATERS, DDS

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, and Discover. Third party, extended payment financing is available upon request and approval with CitiHealth Card.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Additionally, our practice will charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hours notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____

Print Name of Patient or Responsible Party

_____ _____

Signature of Patient or Responsible Party Date