

# BRUCE S. BARKER, D.M.D., P.A.



Creator of Beautiful, Healthy Smiles

PLEASE COMPLETE AND BRING TO YOUR EXAMINATION APPOINTMENT  
(Call if you have questions and we will arrange to assist you in filling out these forms)

## GENERAL INFORMATION

NAME: \_\_\_\_\_  
Last First Middle Birthdate Age  M  F  
Sex

\_\_\_\_\_ S M W D  
Street Address City Zip Code Marital Status

TELEPHONE: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Email Address (for appointment confirmations) \_\_\_\_\_

Preferred method of contact :  Home Phone  Work Phone  Mobile Phone  Email

EMPLOYER NAME \_\_\_\_\_ SOCIAL SEC # \_\_\_\_\_

HOW CAN WE HELP YOU?  GENERAL DENTAL NEEDS  AESTHETIC EVALUATION  EXAM AND CLEANING

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

## SPOUSE/PARENT INFORMATION

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
Last First M.I.

\_\_\_\_\_ Street Address City State Zip Code

TELEPHONE: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ SOCIAL SEC # \_\_\_\_\_

EMERGENCY CONTACT PERSON (if different than listed above) \_\_\_\_\_

## INSURANCE INFORMATION

INSURED'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SUBSCRIBER ID (or SSN#) \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

INSURANCE CO. NAME AND ADDRESS \_\_\_\_\_

\_\_\_\_\_





# BRUCE S. BARKER, D.M.D., P.A.



*Creator of Beautiful, Healthy Smiles*

## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence,

and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$ 50 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## **QUESTIONS AND COMPLAINTS**

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If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information.

# 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}

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## For Office Use Only

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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)

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## DENTAL INSURANCE FACTS

As an optimal-care dental practice, we strongly believe our patients deserve the best possible dental care available today with the newest technologies and new materials. In an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

- **Fact #1** - Your dental insurance is based upon a contract between your **employer** and the **insurance company**. Should questions arise regarding your dental insurance benefits, we can help with basic information, but it is best for you to contact your employer or insurance company directly.
- **Fact #2** - Dental insurance benefits differ greatly from plan to plan. Benefits, coverages, and limitations determine the **quality** of the plan which is solely determined by how much an **employer** chooses to spend on a plan. Hence dental insurance has never been a pay-all form of insurance but provides assistance for dental fees. **Remember, the goal of the insurance company is NOT to help you obtain the best quality of dentistry. Their mission and goal is to garner profit for the insurance company stockholders. Therefore, they will use any and all means to limit your benefits and hence the amount of money they have to pay out.**
- **Fact #3** - You may receive a notification from your insurance company, stating that dental fees are “higher than **usual and customary**.” This is truly a misleading term created by the insurance company. An insurance company surveys a geographic area, calculates an AVERAGE fee, takes 80% of that fee and considers it customary. **This fee limit is different for every carrier and is higher for more expensive plans and lower for less expensive plans.** Our fees maybe higher or lower than a carrier’s “UCR” depending on the **quality** of the plan chosen.
- **Fact #4** - There have been tremendous advances in the last ten years in the way dentistry is performed. Insurance companies continue to promote and therefore cover out-dated and unhealthy ways of restoring teeth while rejecting many of the newer, healthier and long-lasting materials and methods. Our practice strives to use the highest quality materials and the best procedures. **We do not treatment plan for patient’s care base upon what insurance will or will not cover. This is not prudent or ethical and would be considered malpractice. Alternatives will always be explained to help patient’s make an informed decision.**
- **Fact #5** – Some insurance carriers pay differently to dentists depending on whether they are “**in network**” or “**out-of-network**”. A network is a group of dentists under **contract** with the insurance company to perform services at lower fees, thus creating more profit for the insurance company. These practices are typically high volume, lower care offices. We feel that it is **discriminatory** to charge different fees for the same service based on whether a patient has insurance or not. We do not participate in any network run by insurance companies, as they do not support optimal care for our patients.

In summary, the type of treatment you receive from our office is based on professional judgement and a desire to help all patients achieve a lifetime of optimal dental health. Treatment is not based on the limitations of any insurance company as they do not share in keeping the best interests of the patient in mind.

Since dental services are rendered directly to the patient, **you** are directly responsible for payment for services. **As a courtesy to you**, we can file and accept benefits from your insurance carrier. Due to increasing problems associated with most carriers, we have implemented the following policies regarding the handling of insurance:

1. We will electronically file your dental insurance provided we can verify accurate insurance information. The portion of your fee for service that is not covered by your carrier, plus any deductibles, etc is to be paid **at the time of service**. Prior to each visit, we will **estimate** what the insurance portion of your services will be and what you will be responsible for.
2. We will only file **primary** insurance information. If you are covered by a secondary plan, due to the wait time in ability to file, you will be responsible for filing your secondary insurance. We can provide forms to help you.
3. We will accept benefits from your primary carrier up to **60** days from the date of filing. Should there be increased delay by your insurance company past 60 days, the balance will be charged directly to your account, at which time, you are responsible for the fees. Further follow up on your claim becomes your responsibility. A copy of the claim form will be provided to you.

By signing below, you agree to the policies of this office with regard to handling your dental insurance.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

# OFFICE FINANCIAL POLICIES

**We understand that financial situations, like dental treatment plans, differ from person to person. Our goal is to treat each person with optimal dental care, and make recommendations which are ALWAYS in the patients best interests. We have established the following financial choices for our patients.**

*(PLEASE NOTE: IF YOU HAVE DENTAL COVERAGE TO ASSIST YOU, PLEASE REVIEW THE FORM REGARDING DENTAL INSURANCE. DENTAL INSURANCE IS NOT A PAY-ALL AND ALMOST ALWAYS THERE WILL BE CO-PAYMENT REQUIRED FOR DENTAL PROCEDURES.)*

**OPTION 1**

- Payment in full at the time of service. A 5% cash discount will be allowed on charges of \$1000.00 or more if paid by cash or check. Any dental insurance information will be prepared for the patient, but we will instruct your insurance carrier to pay benefits directly to the patient.

**OPTION 2**

- Payment of your estimated co-payment at the time of treatment. Insurance will be filed electronically by our office and benefits will be paid to our office. As stated in the dental insurance policy document, this applies to primary insurance only. Should your insurance company not pay for whatever reason (denied coverage, terminated coverage, exclusion, etc.), the balance of the fee becomes your responsibility and will be automatically charged to your account.

**OPTION 3- (This option does not apply for routine preventive care (cleanings)nor balances under \$ 200.00)**

- Payment of your dental fees on a monthly installment basis. This is arranged with an outside financing company which specializes in providing financing for dental and medical care for those people who qualify. This involves a simple credit approval process which can take place electronically while you are in the office.

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We also request that patients provide us with 48 hours notice in the event they need to change their appointment. The appointment times are reserved exclusively for them, and can be given to other clients provided we have adequate notice. In the event we are not given adequate notice for an appointment change, or an appointment is missed without any notification, the patient may be charged for that appointment.

**Print Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_