Bowen Family Dentistry

Statement of Patient Financial Responsibility

Patient Name: _____**Todays Date:** _____

Parent/Guardian Name: _____**Relationship to Patient**: _____

Bowen Family Dentistry appreciates the confidence you have shown in choosing us to provide for your dental care needs. As a courtesy, we try and verify your coverage prior to your visit (if insurance is provided prior to your appointment) and bill your insurance on your behalf. You are responsible of any deductible and portion that your insurance carrier does not cover. Many dental insurances have additional stipulations that may affect your coverage (waiting periods, service downgrades, etc.). If your dental insurance denies any part of your claim, you will be responsible for the balance. If you fail to pay your portion over 90 days from the day services were rendered, we will be forced to send your account to collections unless other financial arrangements have been made.

I have read the above policy regarding my financial responsibility to Bowen Family Dentistry, for providing dental services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Bowen Family Dentistry, the full and entire amount of bill incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my dental insurance carrier.

Signature: _____ **Date:** _____

Consent Form for Use or Disclosure of Patient Health Information

Instructions: *Please complete and provide to the above dental practice. You may request a copy of this completed form.*

I authorize **Bowen Family Dentistry** to use or to disclose my health information to any necessary party (i.e. my dental/medical insurance company, physician, etc). I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. I understand I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following: *(you may note dates, procedures or use other description)*

_____

Signature: _____

Print name:_____

Date Signed: _____

Signed by: ☐ Patient ☐ Parent/legal guardian
☐ Personal representative of the patient — *describe the legal authority that permits the representation:*