Burke Orthodontics

Helping adults and children "embrace their smiles" with the finest care in traditional braces and invisalign aligners.

Acknowledgement of Review of Notice of Privacy Practices

I give Burke Orthodontics, Inc., permission to contact me by postcard, email or by leaving a message at the address/phone number I have stated on the New Patient form filled out at the initial visit. I have reviewed the office's Notice of Privacy Practice and trust that my health information will only be dispensed in necessary amounts in order to receive the optimal and appropriate care.

Please Print Patient's Name _____

Parent/Guardian's Signature _____ Date _____

For Office Use Only
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) _____

Insurance Information

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Insurance Protocol is important to our professional relationship.
We must emphasize that our relationship is with you, not your insurance company. It is your responsibility to provide us with correct insurance information.

- Your insurance is a contract between you, your employer, and the insurance company.
- We will process the claims for your insurance with the information provided by you as a courtesy.
- It is your responsibility to make sure payments are made in a timely manner.
- Please make sure our office is aware of any changes in coverage or carrier.
- If for any reason your insurance does not pay, it will be necessary for us to bill you directly for the charges.
- Any insurance account over 6 months past due will automatically be billed to you.

Thank you for understanding our Insurance Protocol. If you have any questions about the above information, please ask us. We are here to help you.

Patient _____ ID# _____
Insurance Company (Primary/Secondary) _____
Insurance Address _____
Insurance Phone _____
Insured Name _____ SSN _____ Birth Date _____
Employer _____ Group # _____
Verified Lifetime Orthodontic Max _____

1. I have read the above information. I understand and agree that I am responsible for the payment of all professional services rendered.
2. I authorize payment directly to Burke Orthodontics for any charges covered by insurance.
3. I authorize the release of any medical information necessary to process insurance claims.

Signature _____ Date _____

Stephen P. Burke D.D.S. M.S.
Embrace Your Smile!
www.burke-ortho.com