Nettleton Dental Group

946 East State St.reet
Mason City, Iowa 50401
641-424-4521

Insurance Information

☐ Iowa Title 19 Person ID# (& numbers/1 letter) _____

☐ Dental Insurance

Subscriber Name: _____ Birthdate: _____

Policy #: _____ Group #: _____

Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (please specify) _____

Employer: _____ Phone: (____) _____

Address: _____ City, State, Zip: _____

Insurance company name: _____ Phone: (____) _____

Address: _____ City, State, Zip: _____

As a courtesy to our patients, we will file insurance claims for you with the information you have provided, **HOWEVER**, our professional services are rendered to you and **NOT** the insurance company, therefore, **YOU** are directly responsible for the cost of your treatment.

Please let the receptionist and doctor know if you would like a pre-treatment estimate of coverage from your insurance company.

After your insurance company has made payment, the remainder of your balance is considered payable in full, by you, at that time (please see our Office Financial Policy for payment options).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Please Print Name Relationship to Patient

_____ _____
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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Email Form Print Form Clear Form