

Leo T. Leins D.D.S., P.C.

9552 Park Meadows Drive, Suite 400

Lone Tree, Colorado 80124

303-671-0761

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dr. Leins and the staff at Lone Tree Dental Associates, want to take this opportunity to thank you for choosing our office for your dental care. We Believe that you and your family can achieve an optimum state of dental health. This can only be accomplished through quality dental care and your personal commitment. Welcome to our dental family!

**Office Policy / Fees**: Please be aware there is a fee associated with your visit today. Payment in full is due at the time

services are rendered. If you have dental insurance, you will be required to pay the patient portion

at the time of your visit. If special payment arrangements are necessary, they must be made in

advance prior to your appointment and approved by Dr. Leins. Payment may be made by cash,

check, Care Credit, Visa, Master Card, or Discover. We do NOT accept American Express.

Initials: \_\_\_\_\_\_

**Insurance:** Our office accepts most insurance plans with the exception of Medicare, Medicaid, DMO and

HMO plans. We will assist you in understanding if your plan is in-network or out of network with

our office. We will also file your insurance for you as a courtesy but not a guarantee of payment.

You will be responsible for any amount not covered by your insurance. Dental insurance is a

contract between the patient and the insurance plan. Insurance coverage varies by individual

policy. The staff is happy to assist you when possible, but we do not accept responsibility for

filing your claim, collection from your company, or negotiating a disputed claim.

Initials: \_\_\_\_\_\_

**Appointments:** Please notify us 24 hours in advance within the office hours Monday-Friday, if you must cancel

or reschedule an appointment. *There will be a $75.00 minimum charge for any broken, missed,*

*no-show appointments and appointment not cancelled within the 24-hour notice*. Cancellation

charges vary depending on the amount of time scheduled with the doctor or the hygienist.

Courtesy calls are made 48 hours ahead for appointments scheduled with the doctor and

hygienist. If we are unable to reach you and the appointment is not confirmed, you will be

charged if you fail to arrive for the appointment you scheduled.

Initials: \_\_\_\_\_\_

I certify that I have read and understand the terms of the above information. I understand that my dental insurance

carrier may pay less than the actual bill for services. I agree to the above financial policy and accept full responsibility

for payment of all services rendered on my behalf or my dependents. 1.5% Interest will be charged on accounts with a

balance remaining over 30days. 18% APR. If collection procedures are necessary, the client will be liable for all

collection fees, attorney fees and court costs.

Initials: \_\_\_\_\_\_

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



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**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES**

**I hereby acknowledge that I received Dr. Leins’ Notice of Privacy Practices.**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO SHARE DENTAL INFORMATION**

**I hereby give my permission for a free release and exchange of information regarding my**

**Dental condition and treatment between Dr. Leins, his designated staff, and the following**

**Family members/contact persons:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All information shared is considered confidential.

I do NOT wish to give my information to anyone.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VOICE MESSAGE CONSENT**

**If I am unable to be reached directly by phone, I authorize you to leave voice messages for me at**

**The following numbers:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_