

**Kellie E. Barnes DDS  
2646 E. Joyce Blvd. Suite #1  
Fayetteville, AR 72703**

**AUTHORIZATION FOR DENTAL TREATMENT**

I hereby authorize and direct the provider, and whomever he may designate as his assistance, to administer such treatment as necessary.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I also certify that I have read and fully understand the above authorization for dental treatment.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

Note: Authorization must be signed by the patient, guardian or legally authorized representative.

**APPOINTMENT RESCHEDULING POLICY**

Please understand the necessity of keeping your appointments with Kellie E Barnes DDS. It is very important that you keep your appointment and arrive on time. If cancellation is unavoidable, then please give at least 48 hour notice. Please be aware that missing 3 appointments (without 24 hour notice) will result in you being dismissed as a patient. It is not our intent to be difficult. When a patient misses an appointment it is too late to fill that time slot. That means that another patient needing treatment went without care. Please be considerate of our office and the community of NW Arkansas. Thank you.

Please sign below indicating that you are aware of our policy regarding missed appointments.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

**STATEMENT OF FINANCIAL RESPONSIBILITY**

Please read and initial each statement:

\_\_\_\_\_ It is my responsibility to report any changes in financial abilities, insurance, address or phone number.

\_\_\_\_\_ Failure to pay on my account could result in my being dismissed as a patient, and result in being turned over to a collection agency.

I hereby authorize Kellie E. Barnes DDS to furnish all information regarding my dental history, diagnosis and treatment or my children (if applicable) to an insurance company regarding claims for benefits. If, however, said insurer fails to meet this obligation in whole or part, or if I am not insured, I agree to be responsible for the fees and costs involved in the treatment of the above named patient. I authorize payment of dental benefits to Kellie E. Barnes DDS. I hereby authorize Kellie E. Barnes DDS to act on my behalf in accessing any records when and if I need them.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I have received a copy of the Kellie Barne's Notice Of Privacy Practices (HIPAA form)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date