PATIENT REGISTRATION

Acknowledgement of Receipt
Notice of Privacy Practices
ENDODONTIC SPECIALIST OF BEVERLY

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_________________________Date:________
Signature:___________________________

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)____

------ SIGN THIS PORTION AT A LATER TIME/DATE ——

Right to Revoke:

I have the right at any time to revoke this Acknowledgement for any reason. I have the right to sign this portion **at a later time/date** of my choice to revoke my Acknowledgment.

Signature:_____________________________Date:________

FINANCIAL AGREEMENT/ ASSIGN AND RELEASE

I Acknowledge that payment is due at time of consultation and/or treatment unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for consultation and/or treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for payment of all charges.

I certify that I, and/or my dependent(s), have insurance coverage with ____ and assign
Name of insurance company
Dr. Neil Bonje all insurance benefits, if any, otherwise payable to me for services rendered.

In case outstanding collection services are used to collect prolonged overdue balances, I am responsible for paying the fees incurred for the collection service.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Date

____
Print Signature of Patient, Parent, Guardian or Personal Representative

POLICY for NO SHOW or LATE CANCELLATION:

NO SHOW or LATE CANCELLATION will be charged $150. Re-Scheduling ROOT CANAL appointment after a NO SHOW or LATE CANCELLATION would require $500 deposit. This deposit will be refunded (minus the Co-Pay) for kept appointment, but will not be refunded if LATE CANCELLATION or NO SHOW occurs again.

I read and understand above policy: __________
Initial

In general, the HIPPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as correspondence to the individual's office instead of individual's home

I wish to be contacted in the following manner (Check all that apply)

Where do we send your **POSTAL** mail (for **BILLS** etc.)?
☐ to my home
☐ other_________________________

By providing your phone number, you consent to receive phone calls, text messages, and other communications at this number regarding your care, appointments, billing, and related healthcare information.

Preferred alternate phone number: ____________________________

Additional phone number to contact: __________________________

☐ Leave voicemail message with callback number only

Can we reach you by e-mail?
☐ Yes

Can we call you at work?

☐ Yes. O.K to leave message

☐ Yes. O.K to leave call back number only

____ _______________
Signature of Patient, Parent, Guardian or Personal Representative Date