DENTAL REGISTRATION AND HISTORY

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION And ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I authorize Dr. Neil Bonje and the Endodontic Specialist of Beverly to use my health care information and my personal information, i.e. Date of Birth and Social Security number, to my Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. I also authorize the use of my health information disclosed to my dentist. This consent will end when my current treatment plan is completed or one year from the date signed below. This authorization will renew if new treatment plan is established.

I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization at that time) by notifying Dr. Neil Bonje and the Endodontic Specialist of Beverly in writing.

I may inspect or copy any information used or disclosed under this agreement.

I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

We are required to provide you with a copy of our Notice of Privacy Practices, Which States how we may use and/or disclose your health information. Please sign this form to acknowledge receipt the Notice.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

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

_____
Relationship to Patient

FINANCIAL AGREEMENT/ ASSIGN AND RELEASE

I Acknowledge that payment is due at time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for 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

NO SHOW or Late Cancellations will be charged $150.00 fee _____
initial

Re-Scheduling NO SHOW or LATE CANCELLATIONS of ROOT CANAL APPOINTMENTS will require $500 deposit. The deposit will not be refunded if NO SHOW or CANCELS LATE _____
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 mail ?
- ☐ to my home
- ☐ to my work
- ☐ other_____

Can we call you at home ?
- ☐ O.K. to leave message
- ☐ Leave message with call back number only

Can we call your Cell Phone ?
- ☐ O.K. to leave message or text
- ☐ Leave message with call back number only

Can we reach you by e-mail?
- ☐ yes

Can we call you at Work ?
- ☐ O.K. to leave message
- ☐ Leave message with call back number only

You can call me at this number:
- ☐ _(____)_____

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date