

PATIENT INFORMATION									
PATIENT NAME Last First M.I.					SOCIAL SECURITY NUMBER				
ADDRESS Street					DATE OF BIRTH			SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
City State Zip			HOME PHONE NO.		CELL PHONE NO.		WORK PHONE NO.		
E-MAIL					MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed				
PREFERRED METHOD OF CONTACT <input type="checkbox"/> Home <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> E-Mail									
RACE <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> Filipino <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other					ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic				
PREFERRED LANGUAGE									
2 ND /SEASONAL ADDRESS Street					City			State Zip	
EMPLOYER					PATIENTS OCCUPATION				
EMPLOYER ADDRESS Street					City			State Zip	
PHARMACY NAME					PHARMACY PHONE NO.				
HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> Online <input type="checkbox"/> Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Patient/ Friend/Family Name: <input type="checkbox"/> Physician Name:									
RESPONSIBLE FOR CHARGES									
If person responsible for payment is different from patient, then complete below.									
If patient is child, please indicate if parents are: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced									
NAME					SOCIAL SECURITY NUMBER				
ADDRESS Street					DATE OF BIRTH				
City State Zip					HOME PHONE NO.				
EMPLOYER					EMPLOYER PHONE NO.				
EMPLOYER ADDRESS: Street					City			State Zip	
INSURANCE INFORMATION									
PRIMARY INSURANCE					RELATIONSHIP TO INSURED: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
NAME OF INSURED					SOCIAL SECURITY NUMBER				
INSURANCE NAME					DATE OF BIRTH				
INSURANCE ADDRESS Street					City			State Zip	
EMPLOYER NAME									
EMPLOYER ADDRESS: Street					City			State Zip	
SECONDARY INSURANCE					RELATIONSHIP TO INSURED: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
NAME OF INSURED					SOCIAL SECURITY NUMBER				
INSURANCE NAME					DATE OF BIRTH				
INSURANCE ADDRESS Street					City			State Zip	
EMPLOYER NAME									
EMPLOYER ADDRESS: Street					City			State Zip	

AUTHORIZATION TO DISCLOSE DENTAL HEALTH INFORMATION

I, the undersigned, authorize East Towne Dental Associates to disclose the information described below to the recipient(s) described below. I understand and agree to the statements and information contained in this authorization.

PATIENT INFORMATION

Patient Full Name: _____ DOB: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Other Names During Treatment: _____

RELEASE INFORMATION

Please complete this section and check mark next to the appropriate to/from box for the request to be processed:

☐ Release Information to ☐ Request Information From

Name/Facility: _____ Attention: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Purpose of Request _____

INFORMATION TO BE RELEASED

Please provide information in my dental health records for dates: From: _____ To: _____
Place a check mark next to the requested records:
☐ Complete dental chart ☐ Dental Radiographs Other: _____

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Place a check mark next to the requested records:

☐ Complete dental chart ☐ Dental Radiographs Other: _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

Patient/Guardian Name _____ Date _____

Patient/Guardian Signature _____ Relationship _____

If a personal representative executes this authorization, then the authorization must contain a description of the representative's authority to act for the individual, e.g., "parent" or "guardian ad litem"

East Towne Dental Associates
11501 N Port Washington Rd, Suite 102, Mequon, WI 53092
T: 262.241.8880 • F: 262.241.5250 • E: contactus@easttownedentalassociates.com

To ensure that each patient gets our attention, we set aside dedicated time for you in our schedule. We remind you of your scheduled appointments via text and email for your convenience. However, if you need to cancel or reschedule, we ask that you call or text our office during business hours.

We understand that unexpected issues can arise, and you may need to cancel an appointment. We respectfully ask you to contact our office for at least two business days. Appointments are in high demand, and your early cancellation will give another patient the possibility to access timely dental care.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments.

Missed appointments and last-minute cancellations affect the schedule of the clinicians and take appointments from others in need. To avoid a late cancellation or no-show fee, you must cancel your appointment during regular business hours at least two business days before your scheduled appointment time. If you fail to do so, a \$50/hour of scheduled appointment time fee will be charged to your account.

By signing this form, I am acknowledging that I fully understand East Towne Dental Associates' cancellation policy and accept full financial responsibility for any fee incurred by me due to short-notice cancellation or failed appointment.

Name of Dependents:

Patient/Guardian Name

Relationship

Patient/Guardian Signature

Date

Witness Signature

Date

OFFICE USE ONLY

We were unable to obtain the patient's written acknowledgement due to the following reasons:

- ☐ Patient refused to sign
- ☐ Communication barriers
- ☐ Emergency
- ☐ Other: _____

Taking care of you and your family is our top priority. However, when talking about finances, we need to avoid any chance of misunderstanding by being clear with all fees, financial options, and how you have chosen to handle your financial responsibilities. The result of this form is a financial agreement that we ask you to sign and an official representative to sign so that we can both count on clarity in this important matter.

At the onset of your treatment, we will provide you with an estimate of the total fees expected. Please note that this is an estimate only. Treatment may change for a variety of unforeseen reasons. When estimating insurance payments or coverage, we must also stress the word estimate, as insurance companies continue to surprise us at times. If the insurance company pays more than expected, you will receive a refund. If they pay less than expected or deny the expected benefit, you will receive a balance due on your statement. If your insurance denies your eligibility after the fact, the balance becomes your responsibility. We request the balance due within 30 days of the receipt of your statement. You can request a pre-authorization before beginning the treatment.

PAYMENT OPTIONS

☐ PLAN A: MONTHLY PAYMENT PLANS

For our patients who want to make monthly payments, we offer short- and long-term financing through CareCredit and Lending Club Financing. A member of our business office team will gladly assist you with the application process.

☐ PLAN B: INSURANCE COVERAGE

Our goal is to do whatever it takes to help you maximize your insurance benefits, and as a courtesy, we are happy to bill your dental insurance for services. Please remember that the contract for your insurance coverage is between you, your employer, and your insurance carrier, and your estimated portion is due in full the day of treatment, or you may choose Plan B for your estimated patient portion.

☐ PLAN C: SELF PAY

We accept cash, check*, Debit Card, Discover, Master Card or Visa

INITIAL BELOW

I understand that a \$35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-sufficient fund checks must be redeemed with certified funds (cashier's check, money order or cash)

I understand that I have until two business days before my appointment to cancel or reschedule. If I do not show-up for my appointment or cancelled late, a \$50 per hour (scheduled appointment time) late cancellation or no-show fee may be charged to my account.

I have chosen the above option and accept full financial responsibility for this account. I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office. Any insurance claim not paid in full after 60 days from the date of service will become my responsibility to pay at that time

Name of Dependents:

Patient/Guardian Signature

Date

Financial Coordinator Signature

Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Healthcare Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2009 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer
Jerome Gildner, DDS
11501 N Port Washington Rd, Suite 102
Mequon, WI 53092
T: 262.252.8880

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
T: 877.696.6775

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I _____ give consent for all my protected health information to be shared with:
(Print: Patient or Guardian's Name)

Name

Relationship

Name

Relationship

Emergency Phone Number: _____

Dependent family members also covered by this acknowledgement: _____

Person(s) Authorized to bring and approve treatment for dependent family members:

Name

Relationship

Name

Relationship

Patient/Guardian Signature

Date

Relationship to Patient

OFFICE USE ONLY

We were unable to obtain the patient's written acknowledgement due to the following reasons:

- ☐ Patient refused to sign
- ☐ Communication barriers
- ☐ Emergency
- ☐ Other: _____