



NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Address Information

Mobile phone:		Street address:	
Home phone:		City:	
Email:		State:	
		ZIP:	

Emergency Contact

Work Information

Full Name:		Street address:	
Phone number:		City:	
Relation:		State:	
		ZIP:	

Patient's signature:

Date:



PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: **6320 Venture Dr, Bradenton, FL 34202, USA:**
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental

oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature:

Date:



East Lakewood Dental

6320 Venture Dr, Bradenton, FL 34202, USA

(941) 907 1199

eastlakewooddental.com/

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FINANCIAL POLICY

FINANCIAL POLICY Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care. **INSURANCE:** Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. **PAYMENT:** Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist. **FULL PAYMENT** is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS** and **DEDUCTIBLES** are due at the time of service, unless other arrangements are made. **UNPAID BALANCE** over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account. **MISSED APPOINTMENTS:** Unless we receive notice of cancellation 48 hours in advance, you will be charged \$50. Please help us maintain the highest quality of care by keeping scheduled appointments. I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature:

Date:



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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. East Lakewood Dental offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. East Lakewood Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, East Lakewood Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between East Lakewood Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by East Lakewood Dental.

Patient's signature:

Date:



East Lakewood Dental

6320 Venture Dr, Bradenton, FL 34202, USA

(941) 907 1199

eastlakewooddental.com/

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. East Lakewood Dental, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. East Lakewood Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, East Lakewood Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between East Lakewood Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by East Lakewood Dental.

Patient's signature:

Date:



MEDIA CONSENT

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Patient's signature:

Date: