Patient Registration Form

Please fill out form completely. See back of this form for Notice of Privacy Practices

Patient's First Name: _____ **M.I**._____ **Last Name:** _____

Date of Birth:_____ **Sex:** ❑Male ❑Female **Social Security**#:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address: _____ **City/State/Zip:** _____

Home Phone: _____ ❑OK to leave message **Cell Phone:** _____ ❑OK to leave message

Email: _____ **How did you hear about us?** _____

Emergency Contact: _____ Relationship: _____ Phone #_____

Guarantor Information: ❑Check if same as patient information.

Name: _____ **Relationship to Patient**: _____

Date of Birth: _____ **SSN:** _____ **Sex** ❑Male ❑ Female

Address: _____ **City/State/Zip:** _____

I acknowledge full financial responsibility for any services rendered and I understand payment is due at the time of service. I also understand charges not covered by insurance remain my responsibility. In the event my account is past-due, I agree to pay 1.5% interest as well as a $1 statement fee. I agree to pay all collection fee costs, attorney's fees and court costs, if any. I understand if I do not cancel my appointment, giving 24 hours notice, the clinic may charge a cancellation fee.

X: _____ Date: _____

Patient/Guarantor Signature

Insurance Information:

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Your relationship to the Policy Holder: ❑Self ❑Spouse ❑Child ❑Other _____

Policy Holder's Employer: _____ Policy Holder's SSN: _____

Insurance Company: _____ Policy ID: _____ Group #: _____

Do you have additional dental insurance? ❑Yes ❑No

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Your relationship to the Policy Holder: ❑Self ❑Spouse ❑Child ❑Other _____

Policy Holder's Employer: _____ Policy Holder's SSN: _____

Insurance Company: _____ Policy ID: _____ Group #: _____

Authorization (Optional)

By providing this authorization to release my Personal Health Information (PHI) to the following individual(s), I understand the authorization is voluntary. I understand the PHI to be obtained and released may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy rules. I understand I may revoke this authorization at any time by notifying Bomstad Dental in writing. I hereby authorize Bomstad Dental to use and disclose health information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Consent for Treatment: I consent to the care and treatment by the dentist, his/hers associates, hygienists or assistants. I acknowledge no guarantees have been made as to the effect of such treatment.

X: _____ Date: _____

Patient/Guardian Signature

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please read it carefully

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies of this Notice, please contact Bomstad Dental.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

a. Your PHI may be used and disclosed by the doctor, our office staff and others outside our offices involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of business, and any other use required by law. We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures permissible under federal and state law.

i. **Treatment:** We may use and disclose PHI in order to provide treatment to you. For example, we may use your medication history, to diagnose, treat, and provide dental services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

ii. **Payment:** Under federal law we may use or disclose PHI so services you receive are appropriately billed to, and payment is collected from your dental plan. By way of example, we may disclose PHI to permit your dental plan to take certain actions before it approves or pays for treatment services. We may contact the Guarantor for your visit in order to obtain payment.

iii. **Dental Care Operations:** We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. We will call you by name in the waiting room when we are ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to inform you of dental-related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.

iv. **Required of Permitted by Law:** As required by law, Public Health issues as required by law, Communicable diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement Concerns, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, Inmates and other required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.

b. Permissible Uses and Disclosures That May Be Made Without Your Authorization, But For Which You Have An Opportunity to Object

i. **Family and Other Persons Involved in Your Care.** We may use or disclose dental information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, prior to use or disclosure of your dental information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inference of your best interest in allowing a person to pick up prescriptions, dental supplies, x-rays, or other similar forms of health information.

ii. **Disaster Relief Efforts.** We may use or disclose PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

c. **Other Permitted and Required Uses and Disclosures:** Use or Disclose of your PHI for marketing or sale of your PHI to third parties will be made only with your authorization. Once given, you may withdraw authorization at any time in writing.

II. YOUR INDIVIDUAL RIGHTS

a. **Right to Inspect and Copy.** You may request access to your dental records and billing records maintained by us. All requests to access must be made in writing. Under limited circumstances, we may deny access to your records. Under federal law, you may not inspect or copy psychotherapy notes, information compiled in anticipation of, or use in a legal proceeding, and PHI that is otherwise prohibited. We may charge a fee for the costs of copying and sending you any records requested.

b. **Right to Alternative Communications.** You may request, and we will accommodate, a reasonable written request for you to receive PHI by alternative means of communication.

c. **Right to Request Restrictions.** You may ask us not to disclose any part of your PHI for the purposes of treatment, payment, or health care operations. Your request must be in writing and state the specific restriction requested and to who you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction you may request.

d. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us in the last seven years. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. We are required by law to notify you if your unsecured PHI is breached.

e. **Right to Request Amendment.** You have the right to request we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.

f. **Right to Obtain Notice**. You have the right to obtain a paper copy of this Notice by submitting a request to Bomstad Dental at any time.

g. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned we have violated your privacy rights, you may contact Bomstad Dental. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

a. **Effective Date**. The Notice is effective on January 1, 2024.

b. **Changes to this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our website. You may also obtain any revised notice by contacting Bomstad Dental.

I have reviewed Bomstad Dental Notice of Privacy Practices and understand that I may request a copy of the policy at any time.

SIGNED: _____ DATE: _____