ADVANCED DENTAL CONCEPTS
Complete Family, Cosmetic, and Implant Dentistry

# Welcome

On behalf of Dr. Hayes and our team at Advanced Dental Concepts, we would like to thank you for choosing our practice to care for the dental needs of you and your family. We know that you have many options when choosing a dentist, and we are delighted to welcome you to our dental family, and sincerely appreciate the opportunity to provide you with superb service and high quality, comfortable dental care.

Our practice is uniquely qualified to perform most dental procedures in our office, from basic preventative care...to oral surgery...to implant placement and restoration...to cosmetic porcelain veneers, etc. Not only do we perform most dental procedures in our office, but we also treat patients from age 2 to 102. We love children, and patients of all ages are always welcome.

At your first appointment, Dr. Hayes will complete a comprehensive oral examination. This includes a complete review of your medical and dental history, all necessary x-rays and photographs, study models (if necessary), oral cancer screening, periodontal health evaluation, and examination of your teeth and soft tissues. Following this exam, Dr. Hayes will discuss his findings with you, develop a treatment plan that you are comfortable with, and then we will gladly assist in finding an appointment time that works best for your schedule.

Please prepare for your appointment by printing and completing the new patient registration forms. If you are unable to complete the new patient forms ahead of time, please arrive 30 minutes before your scheduled appointment time. If you have dental insurance, please provide us with your insurance card at your appointment. As a courtesy, we will file claims on your behalf with your dental insurance company. If you would like to finance your dental expenses, we work with CareCredit and will be glad to provide you with information about CareCredit and assist you in the application process right here, in our office. If you have any questions about finances please feel free to ask us at any time.

We know that your time is important; therefore we try to be as punctual as possible. In order to provide this courtesy to all of our patients, it is essential that you inform our office at least forty-eight hours prior to your visit if you are unable to keep your appointment.

Also, please let us know who we may thank for referring you to our practice, as we realize the importance of referrals and we value them greatly. We are always excited to see new smiles coming through our door. Our ultimate goal is to provide you with superb service, exceptional care, and a "unique", pleasant dental experience that you can't wait to tell your family and friends about.

We very much appreciate your confidence in us and look forward to meeting with you!

Sincerely,

Dr. Danny Hayes and Team

***Dr. Danny L. Hayes, DMD***

**Dr. Danny L. Hayes received his Doctor of Dental Medicine (DMD) degree from the prestigious Temple University School of Dentistry in Philadelphia, PA after completing his pre-dental undergraduate studies at Marian University in Indianapolis. Dr. Hayes is a member of the American Dental Association, the Indiana and Northwest Indiana Dental Societies, the Chicago Dental Society, the Winfield Chamber of Commerce, and the Crossroads Chamber of Commerce.**

**Through extensive continuing education, Dr. Hayes is able to provide his patients with the best that 21st century dentistry has to offer.**

**"What I love so much about dentistry today is not just the tremendous technology, not just the satisfaction of creating beautiful and healthy smiles, it's about the relationships that we build with our patients. Through mutual trust, gentle care and true compassion, I feel that the doctor-patient relationship in our practice has become so much more. You will never be a number in our practice as we consider our patients to be family, and we will always treat you in that way."**

**Away from the office, Dr. Hayes enjoys golf, fishing, traveling and spending time with his wife and three lovely children.**

**10780 Randolph Street * Crown Point, IN 46307**
**www.ADC4Smiles.com * supersmiles@ADC4Smiles.com * (219)663-6878**

# PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

**Responsible Party (if someone other than the patient)**

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

**Patient Information**

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

**Primary Insurance Information**

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

**Secondary Insurance Information**

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | High Cholesterol ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Osteoporosis ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pacemaker ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| | | | Yellow Jaundice ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

# DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

**WHAT IS YOUR IMMEDIATE CONCERN?** _____

| PLEASE ANSWER YES OR NO TO THE FOLLOWING: | YES | NO |
|---|---|---|
| **PERSONAL HISTORY** | | |
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____ | ☐ | ☐ |
| 2. Have you had an unfavorable dental experience? _____ | ☐ | ☐ |
| 3. Have you ever had complications from past dental treatment? _____ | ☐ | ☐ |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | ☐ | ☐ |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ | ☐ | ☐ |
| 6. Have you had any teeth removed? _____ | ☐ | ☐ |
| **SMILE CHARACTERISTICS** | | |
| 7. Is there anything about the appearance of your teeth that you would like to change? _____ | ☐ | ☐ |
| 8. Have you ever whitened (bleached) your teeth? _____ | ☐ | ☐ |
| 9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ | ☐ | ☐ |
| 10 Have you been disappointed with the appearance of previous dental work? _____ | ☐ | ☐ |
| **BITE AND JAW JOINT** | | |
| 11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | ☐ | ☐ |
| 12. Do you / would you have any problems chewing gum? _____ | ☐ | ☐ |
| 13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ | ☐ | ☐ |
| 14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ | ☐ | ☐ |
| 15. Are your teeth crowding or developing spaces? _____ | ☐ | ☐ |
| 16. Do you have more than one bite and squeeze to make your teeth fit together? _____ | ☐ | ☐ |
| 17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | ☐ | ☐ |
| 18. Do you clench your teeth in the daytime or make them sore? _____ | ☐ | ☐ |
| 19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ | ☐ | ☐ |
| 20. Do you wear or have you ever worn a bite appliance? _____ | ☐ | ☐ |
| **TOOTH STRUCTURE** | | |
| 21. Have you had any cavities within the past 3 years? _____ | ☐ | ☐ |
| 22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | ☐ | ☐ |
| 23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | ☐ | ☐ |
| 24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ | ☐ | ☐ |
| 25. Do you have grooves or notches on your teeth near the gum line? _____ | ☐ | ☐ |
| 26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | ☐ | ☐ |
| 27. Do you get food caught between any teeth? _____ | ☐ | ☐ |
| **GUM AND BONE** | | |
| 28. Do your gums bleed when brushing or flossing? _____ | ☐ | ☐ |
| 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | ☐ | ☐ |
| 30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | ☐ | ☐ |
| 31. Is there anyone with a history of periodontal disease in your family? _____ | ☐ | ☐ |
| 32. Have you ever experienced gum recession? _____ | ☐ | ☐ |
| 33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | ☐ | ☐ |
| 34. Have you experienced a burning sensation in your mouth? _____ | ☐ | ☐ |

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

# OFFICE and FINANCIAL POLICY

**REGARDING SCHEDULED APPOINTMENTS:**

_____ **(INITIALS)** I hereby agree to show up for my scheduled appointments on time and to give at least a 24 hour advance notice if I need to cancel or reschedule an appointment. I understand that a $50 fee may be assessed to my account without at least 24 hours advance notice of cancellation. I also understand that all cancellation fees must be paid prior to scheduling another appointment. I understand that chronic broken appointments may also result in limited appointment time availability, a non-refundable pre-payment deposit prior to scheduling, and/or possible dismissal from the practice due to chronic failed appointments that negatively impact the effectiveness of this practice. ***A broken appointment is a loss to three people*** - the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

**REGARDING DENTAL INSURANCE:** (We work with most insurance companies)

_____ **(INITIALS)** I understand that I am fully responsible for understanding my insurance policy and the benefits that it provides. I will provide any changes of my insurance policy to Advanced Dental Concepts immediately to ensure prompt claim processing. I also understand that ***I am fully responsible for any dental fees due to Advanced Dental Concepts for treatment performed, regardless of insurance coverage***. Advanced Dental Concepts may provide me with an "estimated" insurance benefit towards dental treatment proposed, however, this is only an estimate and ***there is no guarantee of insurance coverage for any procedure, neither written nor implied, by Advanced Dental Concepts***. If my insurance company pays me, I will provide payment in full at the time of service.

- As a ***courtesy*** to our patients, we will gladly file your insurance claim for you and will make every attempt to fully utilize your insurance benefits to offset "out of pocket" expenses. Please remember, however, that our agreement is with you, not your insurance company. **You, your employer, and your insurance company have an agreement regarding your level of coverage that does not involve Advanced Dental Concepts**.
- We do not determine treatment plans based on insurance coverage. We will always provide you with the best treatment options to care for your own personal dental needs.
- We will provide you with treatment plans and financial estimates for all recommended dental procedures. However, **regardless of insurance benefits for treatment provided, you are responsible for any and all outstanding balances due to Advanced Dental Concepts**.
- "Usual and Customary" fees are determined by your insurance company based on the level of the dental plan that you are enrolled in.

**REGARDING PAYMENT FOR SERVICES RENDERED:**

_____ **(INITIALS)** I understand that I am responsible for payment at the time of service. For some multiple appointment procedures (crowns, bridges, dentures, etc.), payment may be split into multiple payments based upon the number of visits required. However, payment in full must be received before the restoration(s) are delivered. In order to provide you with flexible payment arrangements, the following ***Methods of Payment*** are accepted:

- Dental Insurance Benefits
- Health Savings Accounts (HSA) and Flex Savings Accounts (FSA) (please notify us if you intend to use a HSA or FSA)
- Cash or Check
- Credit Card (Visa, MasterCard, Discover, and American Express)
- ***Visa and MasterCard Health Care Program*****
  (**Our office is a fully approved and accredited user of the ***Visa and MasterCard Health Care Program*** which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance.)
- ***CareCredit*** (*Must qualify, offers reasonable payment plans up to 60 months with some plans 0% interest)

If you wish to apply for ***CareCredit***, inform any of our well trained staff members and we can assist you with the short application process right here in our office. Thank you.

**REGARDING STATEMENTS:**

_____ **(INITIALS)** I understand that account statements will be sent to me monthly. I am aware that the statements display the total account balance due. Once insurance companies have paid their portion, my account balance and statement will be updated accordingly**.**

**OVERDUE ACCOUNTS:**

_____ **(INITIALS)** I understand that account balances more than 30 days overdue are considered delinquent accounts and will incur an additional 2% interest rate per month (24% annual). If my insurance company has not paid within 30 days, I will pay the balance in full and will be refunded any overpayment by Advanced Dental Concepts when my insurance company provides payment. I also understand that account balances more than 90 days overdue will be subject to our collections policy and may negatively affect my credit score and my ability to obtain future credit. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy my financial obligation.

X _____ _____ X _____

Patient Signature Date Office Staff Signature

# GENERAL DENTAL CONSENT

**REGARDING MY MEDICAL HISTORY:**
_____ **(INITIALS)** I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify my provider of any changes at any subsequent appointment.

**REGARDING MINORS UNDERGOING DENTAL TREATMENT:**
_____ **(INITIALS)** I understand that minors (patients under the age of 16) must be accompanied by a parent or legal guardian unless signed written consent is given and the parent is reachable by phone in case of an emergency. Minors may be accompanied by someone other than a parent or legal guardian with written consent except in the case of a dental emergency. In such cases, the Doctor will provide a minimal level of care to stabilize the dental emergency.

**REGARDING GENERAL CONSENT TO DENTAL PROCEDURES:**
_____ **(INITIALS)** I do hereby authorize and request the performance of dental services by Advanced Dental Concepts, and such designated associates or employees, and the use of whatever procedures my Doctor may deem necessary or advisable to maintain my dental health, or the dental health of any minor or other individual for which I am responsible for treatment. Any restorative treatment or therapy such as crowns, fillings and extractions will require my additional consent to treatment.

**REGARDING ANESTHESIA:**
_____ **(INITIALS)** I authorize for myself, and any minor or other individual for which I have responsibility, the administration of any anesthetics, analgesics or sedative, including without limitation, nitrous oxide, therapeutic and/or other pharmaceutical agents (including those related to restorative, palliative, therapeutic, or surgical treatment) that may be deemed appropriate by my Doctor. I understand that anesthetics may be therapeutic, diagnostic, or for treatment of facial pain. I understand that antibiotics, anesthetics, analgesics and other medications may cause complications and reactions including without limitation allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that additional complications may include, but are not limited to, pain, swelling, bruising, temporary limited opening, hematoma, cardiac stimulations, muscle soreness, temporary or permanent numbness, and local infections. I understand that in occasional cases, the anesthesia may be prolonged and in very rare cases, permanent.

**REGARDING DENTAL RADIOGRAPHS:**
_____ **(INITIALS)** I understand that dental x-rays are required to accurately diagnose and provide needed treatment. I understand that if I refuse x-rays, I will not hold Advanced Dental Concepts liable for conditions not diagnosed due to lack of dental x-rays, and for liability issues, further treatment may not be possible.

**REGARDING DENTAL TREATMENT:**
_____ **(INITIALS)** I understand that any treatment plans presented, along with the fees outlined, could change depending on the extent of dental pathology. I understand that once the treatment plan has begun, complications may arise that dictate additional procedures or treatment. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I authorize my Doctor to make any/all changes and additions as necessary.

_____ **(INITIALS)** I understand that a more extensive restoration than originally planned, including but not limited to root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely “permanent” and usually require periodic replacement with additional fillings and/or crowns.

_____ **(INITIALS)** I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees or warranties, neither written nor implied, have been made regarding the dental treatment I will receive.

My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent.

_____ _____
Patient Name (Printed) Date of Birth

X_____ _____
Patient / Guardian Signature Relationship if not patient

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Advanced Dental Concepts has the right to change its Notice of Privacy Practices from time to time and that I may contact Advanced Dental Concepts (10780 Randolph Street, Crown Point, IN 46307) or visit their website (www.ADC4Smiles.com) to obtain a current copy of the Notice.

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 healthcare operations. I also 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.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

### 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 ☐ Communication barriers prohibited acknowledgement

☐ Emergency situation prevented acknowledgement ☐ Other _____

## AUTHORIZATION TO RELEASE INFORMATION

**Purpose:** This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself:

Name / Relationship: _____

Name / Relationship: _____

Name / Relationship: _____

Signature: _____ Date: _____