

Patient Information

Mr. Mrs. Ms. Dr.

Name _____

Home address: _____

(Street)

(City)

(Zip)

Home Phone: _____ Work Phone _____ Car Phone _____

Age _____ Birth Date _____ Email _____ Marital Status S M W D Sep

Employed By _____ Business Address _____

Position _____ How Long _____ Driver's License _____

Spouse's Name _____ Employed By _____ Position _____

Business Address _____ Phone _____

Dental Insurance Info: Do you have dental insurance? yes no Social Security # _____

Insurance Carrier Name _____ Insurance Group # _____

Name of person to notify in Emergency _____ Relationship _____

Address _____ Phone _____

Party Responsible for this account _____

I will pay by: cash check credit card

Name of Dentist _____ How Long _____ City _____

Phone # _____

Name of Physician _____ How long _____ City _____

Phone # _____

Who may we thank for this referral _____

All accounts are due and payable at time of service rendered, unless prior arrangements have been made. If it is desired to extend payments for more than 30 days, specific arrangements must be made with our office. Any unpaid balances or violations of payment arrangements may be subject to a finance charge. Should patient or responsible party fail to pay for services rendered, responsible party agrees to be liable for attorney's fees, collection fees and court costs to enforce payment for services rendered.

So that we may assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once an appointment is made, please remember that this time is reserved for you; at least 24 hours notice must be given if cancellation is absolutely necessary, otherwise cancellation charges will be made.

I have read and understand the above.

Date _____ Signed _____

(or of parent or legal guardian if patient is a minor)



PERIODONTAL AND IMPLANT SPECIALISTS OF BEVERLY HILLS

Ari Rosenblatt, D.D.S., D.M.D., Inc. Ziv Simon, D.M.D., M.Sc., Inc.

I AGREE THAT I WILL GIVE THE OFFICE **24 HOURS NOTICE** FOR ANY **CHANGE** OF APPOINTMENT. I UNDERSTAND THAT I WILL BE CHARGED A FEE FOR ANY APPOINTMENT CHANGED IN **LESS THAN 24 HOURS NOTICE**.

PATIENT SIGNATURE

DATE

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, _____ (Patient's Name) understand that as part of my health care, Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA Notice of Privacy Practices prior to signing this acknowledgement;
- that Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness

Printed Name of Individual or Legal Representative Witness.....

Date:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Others (please specify)

Ms. Anne Rosenblatt
Privacy Official

Date

HIPAA Privacy Rule of Patient Authorization Agreement

Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's name) understand that as part of my health care, Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA Notice of Information practices prior to signing this consent;
- That Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA, is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Ari Rosenblatt, D.M.D. & Associates - Beverly Hills, CA, has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness

Printed Name of Patient or Legal Representative Witness

Date: