IMPRESSION
DENTAL CARE

PATIENT REGISTRATION

PATIENT REGISTRATION FORM

DATE	TITLE ☐ Mr. ☐ Ms ☐ Mrs. ☐ Dr.	FIRST NAME	LAST NAME

Patient Information

HOME ADDRESS			CITY		STATE	ZIP CODE
HOME PHONE	**WORK PHONE**		**MOBILE**		**NUMBERS OK TO LEAVE MESSAGE:** ☐ home ☐ work ☐ mobile	
SOCIAL SECURITY NO.	**DATE OF BIRTH**	**AGE**	**SEX** ☐ M ☐ F	☐ Single ☐ Married	☐ Separated ☐ Divorced	☐ Widowed
DRIVER'S LICENSE	**EMAIL**		☐ I would like to receive correspondences via email/mail.			
EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ Retired			**STUDENT STATUS** ☐ Full Time ☐ Part Time			

☐ Primary Ins. Policy Holder ☐ Secondary Ins. Policy Holder ☐ Responsible Party is also a Policy Holder for Patient

Responsible Party (if someone other than the patient)

FIRST NAME			LAST NAME			
HOME ADDRESS			**CITY**		**STATE**	**ZIP CODE**
HOME PHONE	**WORK PHONE**		**MOBILE**		**NUMBERS OK TO LEAVE MESSAGE:** ☐ home ☐ work ☐ mobile	
SOCIAL SECURITY NO.	**DATE OF BIRTH**	**AGE**	**SEX** ☐ M ☐ F	☐ Single ☐ Married	☐ Separated ☐ Divorced	☐ Widowed
DRIVER'S LICENSE	**EMAIL**		☐ I would like to receive correspondences via email.			
EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ Retired			**STUDENT STATUS** ☐ Full Time ☐ Part Time			

Who may we thank for your referral?

☐ Friend/Patient ☐ Newspaper ☐ Radio ☐ Lecture/Seminar ☐ Special Event
☐ Directory ☐ Magazine ☐ Television ☐ Direct Mail ☐ Other

NAME OF REFERRAL SOURCE

Consultation Notes (Office Use):

ALLERGIES/MEDS/MEDICAL CONCERNS:

CHIEF CONCERN:

AREA OF DISCOMFORT (IF ANY):

FINDINGS:

TREATMENT OPTIONS DISCUSSED:

NEXT VISIT:

IMPRESSION
DENTAL CARE

DENTAL QUESTIONAIRE

DENTAL QUESTIONNAIRE

DATE	TITLE ☐ Mr. ☐ Ms ☐ Mrs. ☐ Dr.	FIRST NAME	LAST NAME

Smile Analysis

Looking into a full face, close up mirror, analyze your smile and answer the following:

In a slight smile, do the tips of your teeth show?	☐ Yes ☐ No	Are the two upper front teeth longer than the others?	☐ Yes ☐ No
Are your upper front teeth too long?	☐ Yes ☐ No	Are your upper front teeth too short?	☐ Yes ☐ No
Do your front teeth have spaces between them?	☐ Yes ☐ No	Are your front teeth crooked?	☐ Yes ☐ No
Are all of your teeth the same color?	☐ Yes ☐ No	Do your teeth have yellow or brown stains?	☐ Yes ☐ No
Do your gums show too much when you smile?	☐ Yes ☐ No	Do you have fillings that show when you smile?	☐ Yes ☐ No
Are your gums pink & healthy? (not red and swollen)	☐ Yes ☐ No	Do you notice receding gums?	☐ Yes ☐ No
Are you concerned about your breath?	☐ Yes ☐ No	Do you know the difference between clean teeth and a healthy mouth?	☐ Yes ☐ No

General (Pleae answer only the questions in black)

HOW OFTEN DO YOU BRUSH?	HOW OFTEN DO YOU FLOSS?	TOOTHPASTE:	MOUTHWASH:

OTHER:	ORAL CANCER: ☐ Yes ☐ No ☐ High Risk	AREA:
EMOTIONAL MOTIVATORS:	TMJ: ☐ Yes ☐ No	EXPLAIN:
EMOTIONAL CONCERNS:	BLOOD PRESSURE (OFFICE USE):	PULSE (OFFICE USE):

MAXILLARY ANTERIOR PAIN (OFFICE USE):				MANDIBULAR ANTERIOR PAIN (OFFICE USE):			
Dental:	Low / High	Acute / Chronic	None	Dental:	Low / High	Acute / Chronic	None
Mucosal:	Low / High	Acute / Chronic	None	Mucosal:	Low / High	Acute / Chronic	None
MAXILLARY POSTERIOR PAIN (OFFICE USE):				MANDIBULAR POSTERIOR PAIN (OFFICE USE):			
Dental:	Low / High	Acute / Chronic	None	Dental:	Low / High	Acute / Chronic	None
Mucosal:	Low / High	Acute / Chronic	None	Mucosal:	Low / High	Acute / Chronic	None

Habits

GRIND TEETH:				BITE CHEEK:			
☐ None	☐ Maybe	☐ Yes (Present)	☐ History of	☐ None	☐ Maybe	☐ Yes (Present)	☐ History of
TONGUE THRUST:				MOUTH BREATHER:			
☐ None	☐ Maybe	☐ Yes (Present)	☐ History of	☐ None	☐ Maybe	☐ Yes (Present)	☐ History of
BULIMIA/ANOREXIA:				CIGAR/CIGARETTE			
☐ None	☐ Maybe	☐ Yes (Present)	☐ History of	☐ None	☐ Maybe	☐ Yes (Present)	☐ History of
PIPE:				BITE NAILS:			
☐ None	☐ Maybe	☐ Yes (Present)	☐ History of	☐ None	☐ Maybe	☐ Yes (Present)	☐ History of
SMOKELESS TOBACCO:				THUMB/FINGER:			
☐ None	☐ Maybe	☐ Yes (Present)	☐ History of	☐ None	☐ Maybe	☐ Yes (Present)	☐ History of
TOOTHPICK/STIMULATOR:				CHEWING GUM:			
☐ None	☐ Maybe	☐ Yes (Present)	☐ History of	☐ None	☐ Maybe	☐ Yes (Present)	☐ History of
CANDY:				SOFT DRINKS:			
☐ None	☐ Maybe	☐ Yes (Present)	☐ History of	☐ None	☐ Maybe	☐ Yes (Present)	☐ History of
OTHER:				Description: _____			
☐ None	☐ Maybe	☐ Yes (Present)	☐ History of				

History

ARE YOUR TEETH SENSITIVE TO:

Hot or Cold:	☐ Present	☐ Past	☐ Never
Biting/Chewing:	☐ Present	☐ Past	☐ Never
Sweets:	☐ Present	☐ Past	☐ Never

COMMENTS:

HAVE YOU EVER HAD:

Orthodontic Treatment:	☐ Present	☐ Past	☐ Never
A bite plate or guard:	☐ Present	☐ Past	☐ Never
Periodontic Treatment:	☐ Present	☐ Past	☐ Never
Oral Surgery:	☐ Present	☐ Past	☐ Never
Serious injury to mouth or head:	☐ Present	☐ Past	☐ Never

IMPRESSION
DENTAL CARE

MEDICAL HISTORY

Medical History Form

DATE	TITLE ☐ Mr. ☐ Ms ☐ Mrs. ☐ Dr.	FIRST NAME	LAST NAME

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 treatment you will receive. Thank you for answering the following questions.

Medical History—Please check if you have or have had any of the following

Are you under a physician's care now?	☐ Yes ☐ No ☐ N/A	IF YES, PLEASE EXPLAIN
PHYSICIAN NAME		PHONE
Have you been hospitalized or had any operation?	☐ Yes ☐ No ☐ N/A	IF YES, PLEASE EXPLAIN
Have you ever had a serious head or neck injury?	☐ Yes ☐ No ☐ N/A	IF YES, PLEASE EXPLAIN
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No ☐ N/A	IF YES, PLEASE EXPLAIN (USE THE BACK OF THE PAGE IF NEEDED)
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No ☐ N/A	IF YES, PLEASE EXPLAIN
Are you on a special diet?	☐ Yes ☐ No ☐ N/A	IF YES, PLEASE EXPLAIN
Do you use tobacco (smoke or chew)?	☐ Yes ☐ No ☐ N/A	
Do you use controlled substances?	☐ Yes ☐ No ☐ N/A	IF YES, PLEASE EXPLAIN

Women: are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other: _____ Pharmacy Name: _____ Phone: _____

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Dialysis
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Rheumatic Fever
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatism
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Breathing Problem	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Tonsilitis
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Chest Pains	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Pace maker	☐ Radiation Treatments	☐ Yellow Jaundice
☐ Convulsions	☐ Heart Trouble/Disease	☐ Recent Weight Loss	

Have you ever had any serious illness not listed above?	☐ Yes ☐ No ☐ N/A	IF YES, PLEASE EXPLAIN

Dental Consent

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. I authorize for the doctor and his or her staff to evaluate, diagnose, recommend treatment, provide treatment and use appropriate medication as needed. I understand that using anesthetic agents embodies certain risks, and each treatment has its risks and benefits. I consent to and accept the risks associated with my dental treatment.

Signature: **Date:**

IMPRESSION
DENTAL CARE

FINANCIAL OPTIONS

FINANCIAL POLICY

Our mission is to deliver the finest, most comprehensive and cost effective dental care treatment available.

PAYMENT OPTION A

- **Full payment is made with cash, check or credit card prior to start of treatment.**
- If you have dental insurance, we will assist you in receiving a reimbursement check for the services that were eligible for coverage.
- We offer a 5% courtesy accounting adjustment to patients who utilize this option.

PAYMENT OPTION B

- **Full payment is made utilizing a financing company prior to start of treatment.**
- We will assist you in financing your dental work on approved credit.
- Convenient monthly payment plans allow you to pay over time with no annual fees or pre-payment penalties.

PAYMENT OPTION C*

- **Split payments are made with a combination of dental insurance and other forms of payments.**
- Insurance deductible, estimated co-pay and applicable deposits are made prior to start of treatment.
- Services with possible eligibility for insurance benefit is billed to the insurance company.
- Once insurance payment is applied to the account (if applicable), the remaining balance is billed to the responsible account holder.
- Additional information pertaining to dental insurance is available on Impression Dental Care's Authorization Form.

NOTE FOR ALL PATIENTS

- A 25% deposit will be required at the time of appointment scheduling to reserve 1 or more hour(s) of the doctor's time or 2 or more hours of the hygienist's time.
- A fee of $50 will be charged for patients who miss or cancel without a 24-hour notice.
- A fee of $50 will be charged for each returned check.
- Personal checks in the amount of $500 or more must be paid 10 business days prior to start of treatment.

IMPRESSION DENTAL CARE & THE IMAGE CENTER VIP REWARD PROGRAM

- VIP Reward Points have no redeemable cash value, is nontransferable and is subject to present and future program and conditions.
- Certain product exclusions may apply and website products are not eligible for VIP Reward Points or discounts.
- 2 Points = $2 towards any services offered at The Image Center (dental, plastic surgery or spa)

* Dental services being paid via "Payment Option C" are not eligible for earning VIP Reward Points.

I understand and agree to Impression Dental Care's Financial Policy.

PATIENT, PARENT OR GUARDIAN SIGNATURE _____ DATE _____

PATIENT NAME (PLEASE PRINT) _____ DATE _____

NOTICE OF PRIVACY PRACTICES

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines that they will need to consult with another specialist in the area. The physician will share the information with such specialist and obtain the specialist's input.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/hospital;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the office/hospital;
  - Is not part of the information that you would be permitted to inspect and copy; or,
  - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact the Privacy Officer at the end of this notice, in person or in writing, during regular, business hours. The privacy officer will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

Our office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Privacy Officer at the end of this notice. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Privacy Officer, Vanessa Gamboa at 7801 Center Ave Huntington Beach, CA 92647. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
- We would like the opportunity to keep you informed of the services offered by all of the Image Center's providers, including Image Plastic Surgery, Impression Dental Center, Huntington Surgery Center, and Minuet Day Spa.
- You agree to allow us to provide you information on an ongoing basis about all of the Image Center's services.
- Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services beyond those offered by the Image Center's providers without obtaining additional consent from you
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the NOTICE OF PRIVACY PRACTICES and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Signature Date

Impresssion Dental Care · 7801 Center Avenue Suite 101 · Huntington Beach Ca 92647 · 714.230.2410 · 714.230.2411 fax · ImpressionDental.com

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is available for your review in the laminated pages that accompany your registration forms, or by request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. The Image Center is a comprehensive aesthetic and wellness center with highly integrated services; including plastic surgery (Image Plastic Surgery), outpatient surgery (Huntington Surgery Center), dentistry (Impression Dental Care) and skin care (The Spa at The Image Center). In the normal course of providing care, Image Center staff often work in more than one area of the Center. All Image Center staff members are held to the highest levels of confidentiality, and are allowed to access your patient information only to the extent necessary to provide for your care.
2. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
3. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
4. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
5. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
7. We would like the opportunity to keep you informed of the services offered by all of the Image Center's providers, including Image Plastic Surgery, Huntington Surgery Center, Impression Dental Center, and The Spa at The Image Center. You agree to allow us to provide you information on an ongoing basis about all of the Image Center's providers and services. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services beyond those offered by the Image Center's providers without obtaining additional consent from you.
8. We agree to provide patients with access to their records in accordance with state and federal laws.
9. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
10. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Signature Date

IMPRESSION
DENTAL CARE

INSURANCE AUTHORIZATION

AUTHORIZATION FORM

Credit Card Authorization (All Patients)

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

BANK NAME	CARD TYPE		
ACCOUNT NUMBER	EXPIRATION DATE		
CARD HOLDER NAME			
CARD HOLDER'S ADDRESS	CITY	STATE	ZIP CODE
PATIENT NAME			
PATIENT'S ADDRESS	CITY	STATE	ZIP CODE

I authorize **Impression Dental Care** to charge my credit card or debit card for any cancelation fee or returned check fee due on my credit card **immediately upon occurrence per policy** and/or for any balance still owing on my account **45** days from the date of service. I understand that I am responsible for any balance due for services my family or I have received regardless of insurance benefits and/or estimate.

CARD HOLDER'S SIGNATURE _____ DATE _____

Primary Insurance Information (Policy Holders)

NAME OF INSURED	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Child ☐ Other		
SOCIAL SECURITY	BIRTH DATE	EFFECTIVE DATE	
EMPLOYER		PHONE#	
INSURANCE COMPANY	GROUP#	PHONE#	

Secondary Insurance Information

NAME OF INSURED	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Child ☐ Other		
SOCIAL SECURITY	BIRTH DATE	EFFECTIVE DATE	
EMPLOYER		PHONE#	
INSURANCE COMPANY	GROUP#	PHONE#	

Dental Insurance Policy & Authorization

Although we are not an in-network provider with your Insurance Company we are happy to work with your carrier to maximize your benefits. Under Payment Option C, the estimated insurance portion of the treatment will be billed to your Insurance Company. If the Insurance Company sends the check to us and the received amount creates a positive balance on your account, we will apply the credit to your future treatment or give you a refund.

If further balance remains after the insurance payment has been applied or if the insurance company denies the claim, the balance will be due immediately. If a payment is not received within 45 days from the date of treatment, the **remainder of the balance will be charged to your credit card**.

I hereby authorize and request my Insurance Company to pay directly to Impression Dental Care in the amount due on my claim for services rendered to me or my dependent. I also understand and agree to Impression Dental Care's Financial and Dental Insurance Policy.

INSURANCE POLICY HOLDER'S SIGNATURE _____ DATE _____