ACQUAINTANCE FORM

Date_____

Jain Dental
952-926-3392

PATIENT Name_____ What do you prefer to be called_____

Home Phone _____

Work Phone_____

Cell Phone _____

Home Address_____

City _____ State _____ Zip Code_____

Email Address _____

Employed by _____

Employment Address _____

SPOUSE'S Name_____

Home Phone _____

Work Phone_____

Address (if different)_____

City _____ State _____ Zip _____

Employed by _____

Employment address_____

City _____ State _____ Zip _____

Date of birth _____ Social Security # _____

City _____ State _____ Zip Code _____

Position _____

Date of birth_____Social Security #_____

Who referred you to our office? _____

In case of emergency, name of who we should contact:_____

Relationship _____Phone number_____ City _____

Person responsible for account: Self _____Other_____

Dental insurance carrier _____ Policy holder_____ Group# _____ ID #_____

Secondary dental insurance _____ Policy holder_____ Group# _____ ID #_____

I authorize release of any information relating to my claims.

Signature_____Date_____

I hereby authorize payment of benefits to Jain Dental, P.L.L.C.

Signature_____Date_____

Circle if you have: Medicare, Minnesota Care, Medical Assistance, or General Assistance.

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself, and give my consent to any advisable and necessary dental procedures and medications to be administered by the attending dentist or by his/her supervised staff.
I understand and acknowledge that I am financially responsible for the services provided, regardless of insurance coverage.
I understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee.
I understand that a FINANCE CHARGE of 1.5% per month (18% APR) will be applied to accounts 30 days past due.

PATIENT SIGNATURE_____

Jain Dental, P.L.L.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Social Security #: _____ Telephone: _____

Address: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Mary Jo – Office Manager Telephone: (952) 926-3392 Fax: (952) 926-3721 Address: 4600 Excelsior Blvd, St. Louis Park, MN 55416

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

I wish to be contacted in the following manner (check **ALL** that apply):

- o Home telephone _____
- o Ok to leave a message with detailed information
- o Ok to leave a message at home with call back number only

- o Mobile telephone _____
- o Ok to leave a message with detailed information
- o Ok to leave a message on a mobile with call back number only
- o Ok to text a message on mobile

- o E-mail address _____
- o Ok to e-mail a message with detailed information

I allow Jain Dental to give my clinical information including but not limited to treatment information, account information, insurance information and all other PHI to: (check **ALL** that apply)

- o Spouse (name) _____

- o Parent(s) _____

- o Children _____

- o Other _____

- o None

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth