ENDODONTICS ASSOCIATES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME:____

ADDRESS:____

TELEPHONE:_______________________ SOCIAL SECURITY NUMBER:___________________

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:

Privacy Officer
1199 Colonial Road, Harrisburg, PA 17112
Phone: (717)545-7400 Fax: (717)909-6865

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 Privacy Officer. 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 healthcare operations.

Signature:____Date:____________________________

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

Personal Representative's Names:____

Relationship to Patient: ____

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YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

ENDODONTICS ASSOCIATES

FINANCIAL POLICY AND RELEASE OF BENEFITS

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Feel free to ask about our fees, financial policy or your responsibility.

REGARDING INSURANCE

We participate with **United Concordia, Delta Dental, Capital Blue Cross Dental and UPMC Advantage. We do not participate with any medicare plans within these groups.** Copayments are due at the time treatment is rendered. We do our best to calculate your copayment as accurately as possible; however, differences can occur which may result in us sending either a bill for additional monies due or a refund if we receive a higher payment from your insurance. It is ultimately your responsibility to understand the extent and limits of your coverage. We cannot enter into disputes between you and your insurance company regarding copayments, deductibles, etc.

NO INSURANCE OR NON-PARTICIPATING INSURANCE

Full fee is due at the time treatment is rendered. If we do not participate with your insurance, as a courtesy we will file your claim for you to your dental insurance company; however, you must make sure to provide us with accurate information for the correct and timely filing of the claim (i.e. correct claim address, correct ID#s, etc.). If incorrect information is given it will result in the delay of reimbursement from your insurance.

We offer a payment discount to those patients who have no dental insurance or an insurance with which we do not participate and are responsible for the full cost of the treatment. A 5% discount is given with check or cash or a 3% discount is given with a credit or debit card. ***Discount applies only to Root Canal Therapy, Retreatment Therapy or Apicoectomy

We do participate with the **Carecredit** payment card, but it may only be used for amounts of $300 or more.

APPOINTMENTS

Patients who cannot make their scheduled appointments are expected to give 24-hour notice. Broken appointments gives Endodontics Associates the right to dismiss patients from the practice.

RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize ENDODONTICS ASSOCIATES to release to the insurance company or its representative any information including diagnosis and records of any treatment or examination rendered to me.

Signature: ______________________________

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO BE FINANCIALLY RESPONSIBLE (PAYMENTS AND/OR COPAYMENTS) FOR ANY SERVICES RENDERED.

Print Name: ______________________________

Signature: ______________________________Date: ____________________

Endodontics Associates

1199 Colonial Rd. Harrisburg, PA 17112
395 St. John's Church Rd. Camp Hill, PA 17011
1108 E. Chocolate Ave. Hershey, PA 17033

Patient Information

Patient Name:________________________ Sex: M F Birthdate:__________
What name would you like to be addressed? ________________________
Mailing Address: ________________ City:____________ State:______ Zip:______
Phone: Home______________ Work______________ Ext_____ Cell______________
Employer:________________________ Occupation:________________________
Emergency Contact:________________________ Phone:________________________
Your Email Address: ________________________
Dentist Name:________________________

Primary Dental Insurance Information

Insurance Company: ________________________
Address:________________________
Policy Holder's Name: ________________________
Birthdate:________________________ ID#:________________________
Employers Name:________________________ Group #:________________________

Secondary Dental Insurance Information

Insurance Company: ________________________
Address:________________________
Policy Holder's Name:________________________
Birthdate:________________________ ID#:________________________
Employers Name:________________________ Group #:________________________

Medical History

Are you allergic to any of the following?

Penicillin	**Yes**	**No**	**Sedatives**	**Yes**	**No**
Sulfa Drugs	**Yes**	**No**	**Barbiturates**	**Yes**	**No**
Erythromycin	**Yes**	**No**	**Steroids**	**Yes**	**No**
Clindamycin	**Yes**	**No**	**Novocain**	**Yes**	**No**
Motrin/Advil	**Yes**	**No**	**Vicodin**	**Yes**	**No**
Aleve	**Yes**	**No**	**Valium**	**Yes**	**No**
Aspirin	**Yes**	**No**	**Latex**	**Yes**	**No**
Codeine	**Yes**	**No**	**Other** ________________		

Office Use Only:

Medical Hx Reviewed by: ________________________ **Date:** ______________

Have you had or do you currently have any of the following?

Heart Trouble	Yes	No	Irritable Bowel	Yes	No
Heart Murmur	Yes	No	Colitis	Yes	No
High Blood Pressure	Yes	No	HIV/AIDS	Yes	No
Angina	Yes	No	Osteoporosis	Yes	No
Stroke	Yes	No	Fainting Spells	Yes	No
Mitral Valve Prolapse	Yes	No	Herpes	Yes	No
Congenital Heart	Yes	No	Arthritis	Yes	No
Anemia	Yes	No	Radiation Therapy	Yes	No
Migraines	Yes	No	Kidney Trouble	Yes	No
Pacemaker	Yes	No	Psychiatric Care	Yes	No
Tuberculosis	Yes	No	Blood Disorders	Yes	No
Convulsions	Yes	No	Lung Diseases	Yes	No
Thyroid Trouble	Yes	No	Diabetes	Yes	No
Hepatitis A, B, C	Yes	No	Joint Replacement	Yes	No
Epilepsy	Yes	No	Cancer	Yes	No
Other					

General Questions

General Health: Excellent Good Fair Poor

Name of your family Physician:______________________________

Have you ever had root canal treatment? Yes No

Are you taking any medications at this time? Yes No

List medications:______________________________

Are you pregnant? Yes No Months_____

Are you currently taking birth control? Yes No

Have you been hospitalized in the past 2 years? Yes No

If YES for what?______________________________

Have you ever been treated for substance abuse? Yes No

Do you currently premedicate with antibiotics due to any type of prosthesis, joint replacement(s), and or heart conditions? Yes No

Do you have an artificial heart valve? Yes No

Are you taking or have you taken a bisphosphonate such as Fosamax, Actenol or Boniva? Yes No

Do you take a blood thinner? Yes No

Is there anything else about your health we should know?

Patient Signature *(guardian)*______________________________ Date____________