St. Johns
ENDODONTICS

John M. Sullivan, DMD, MS
Board Certified Endodontist
Thomas P. Currie, DMD, MS
Board Certified Endodontist
Alexander R. McClure, DMD

PATIENT INFORMATION

Name: _____ S.S.N: _____

Address: _____ Home Phone: _____

City: _____ State:_____ Zip:_____ Work Phone:_____

Email: _____ Cell Phone: _____

General Dentist: _____

Payment is due at time of service, please indicate your method of payment:

☐ Cash ☐ Check ☐ Credit/Debit Card (No Amex) ☐ Care Credit ☐ HSA/FSA

Insurance Policy

We accept most insurance assignments for dental services; however the patient is legally and financially responsible for all cost of dental services regardless of dental insurance coverage. If the insurance does not pay within 60 days of the date the claim was filed, the account becomes due and payable by the patient. It is the patient's responsibility to notify us immediately regarding any changes to benefit coverage. If the insurance company denies a claim, the patient is legally and financially responsible for any service rendered. REMEMBER we will give only an ESTIMATE of the patient's copayment. This is an estimate based on what the insurance company provided our office. If the insurance company does not pay the estimated amount, the patient is fully responsible for the balance. The patient understands that insurance benefits are not a substitute for payment by the patient.

Overdue Fees: Please be advised that should your account be turned over to a collection agency, all costs to collect overdue fees as allowed by law, will be your responsibility, including collection costs and/or attorney fees.

Thank you.

Signature:_____

Date _____

_____

(If under 18 Parent or Legal Guardian

Relationship to patient _____

Consent for Use and Disclosure of Health Information

Purpose: In cases where St. Johns Endodontics has been directed not to rely on acknowledgement as a basis to use or disclose health information, this form is used to obtain a patient's consent for our use and disclosure of the patient's protected health information to carry out treatment, payments activities, and healthcare operations, as more fully in our Notice of Privacy Practices.

Name: I _____ (please print) 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 options.

Signature:_____

Date _____

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

_____

Personal Representative's Name Signature

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To The Patient – PLEASE READ the following statements carefully

Purpose of Consent: By signing this form you 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 of 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.

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.

Right to Revoke: You will have the right to revoke the consent at any time by giving us a written notice of your revocation. Please understand that revocation of consent will not affect any action we have taken 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.