Patrick T. Yoshikane, DDS

Welcome to Our Office

PERSONAL INFORMATION

Date: _____

Name: _____ Gender □ M □ F Age: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Drivers Lic. #: _____ SS#: _____ Status: □ Single □ Married □ Divorced □ Widowed

Patient Employer/School: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer/School Phone: _____

Name of Spouse: _____ SS#: _____ Cell Phone: _____
(responsible party if minor)

Spouse Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Who is your PHYSICIAN? _____ Phone #: _____

DENTAL INSURANCE AND FINANCIAL INFORMATION

Responsible Party: _____ DOB: _____

Relationship to Patient: _____ Phone Number: _____ SS#: _____

Insurance Carrier: _____ Group #: _____ ID#: _____

SECONDARY INSURANCE INFORMATION

Is patient covered by additional insurance? □ Yes □ No

Responsible Party: _____ DOB: _____

Relationship to Patient: _____ Phone Number: _____ SS#: _____

Insurance Carrier: _____ Group #: _____ ID#: _____

ASSIGNMENT AND RELEASE OF BENEFITS

We invite you to discuss with us any questions regarding our services. The best dental health services are based on friendly, mutual understanding between provider and patient. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Patrick T. Yoshikane, DDS, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ □ Adult Patient □ Parent or Guardian □ Spouse Date: _____

DENTAL HEALTH HISTORY

Reason for today's visit: _____ Previous dentist: _____ Last dental visit: _____

Check any of the following which you have had or have at present:

	YES	NO		YES	NO		YES	NO
Bad Breath	❑	❑	Grinding teeth	❑	❑	Pain around ear	❑	❑
Bleeding Gums	❑	❑	Gums swollen or tender	❑	❑	Periodontal treatment	❑	❑
Burning sensation on tongue	❑	❑	Lip or cheek biting	❑	❑	Sensitivity to cold	❑	❑
Chew on one side of mouth	❑	❑	Loose teeth or broken fillings	❑	❑	Sensitivity to heat	❑	❑
Dry Mouth	❑	❑	Mouth breathing	❑	❑	Sensitivity to sweets	❑	❑
Fingernail biting	❑	❑	Mouth pain, brushing	❑	❑	Sensitivity when biting	❑	❑
Food collection between teeth	❑	❑	Orthodontic treatment	❑	❑			

How often do you brush your teeth? _____ How often do you floss? _____

See other side>>>>>

MEDICAL HEALTH HISTORY

1) Have you been under the care of a medical doctor during the past two years? ☐ No ☐ Yes, explain: _____

2) Have you been a patient in the hospital during the past two years? ☐ No ☐ Yes, explain: _____

3) Please rate your general health from 1 to 10 (with 10 being the healthiest)_____ WOMEN: Are you pregnant? ☐ No ☐ Yes

4) Are you allergic (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex or any drugs or medications? ☐ No ☐ Yes _____

5) Have you ever taken Phen-fen or Redux? ☐ No ☐ Yes Are you currently taking Bisphosphonate/Fosamax? ☐ No ☐ Yes

6) Please list any medications you are currently taking (including herbal supplements) _____

_____

7) Check any of the following which you have had or have at present:

CARDIOLOGY	YES	NO
Heart Failure	❑	❑
Heart Attack	❑	❑
Heart Defects	❑	❑
Angina Pectoris	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
Congenital Heart Lesions	❑	❑
Scarlet Fever	❑	❑
Artificial Heart Valve	❑	❑
MVP (Mitrovalve Prolapse)	❑	❑
Pacemaker / Defibrillator	❑	❑
Heart Surgery	❑	❑
Hardening of Arteries	❑	❑
Family History of Heart Disease	❑	❑
Stroke	❑	❑

UROLOGY		
Kidney Trouble / Disease	❑	❑
Liver Disease	❑	❑
Bladder Disease	❑	❑

GASTROENTEROLOGY		
Stomach Problems or Ulcers	❑	❑
Eating Disorders	❑	❑
Digestive Problems	❑	❑
Intestinal Infection	❑	❑

EARS, NOSE & THROAT	YES	NO
Loss of Hearing	❑	❑
Ear Infection	❑	❑
Allergies or Hives	❑	❑
Asthma	❑	❑
Breathing Problems	❑	❑
Sinus Problems	❑	❑
Snoring	❑	❑
Emphysema	❑	❑
Cough	❑	❑
Hay / Scarlet Fever	❑	❑
Rheumatic Fever	❑	❑
Thyroid Disease	❑	❑

SKIN		
Acne	❑	❑
Skin Rash	❑	❑
Shingles	❑	❑

PSYCHIATRIC		
Anxiety	❑	❑
Depression	❑	❑
Nervousness	❑	❑
Psychiatric Treatment	❑	❑
Fainting / Dizziness	❑	❑
Epilepsy or Seizures	❑	❑
Frequent Headaches	❑	❑

BLOOD THINNERS		
Warfarin (Coumadin)	❑	❑
Clopidogrel (Plavix)	❑	❑
Aspirin	❑	❑

DISEASE	YES	NO
Diabetes	❑	❑
AIDS	❑	❑
Hepatitis A	❑	❑
Hepatitis B	❑	❑
Hepatitis C	❑	❑
Yellow Jaundice	❑	❑
Blood Transfusion	❑	❑
Anemia	❑	❑
Leukemia	❑	❑
Tuberculosis	❑	❑
Hemophilia	❑	❑
Venereal Disease	❑	❑
Cold Sores	❑	❑
Genital Herpes	❑	❑
Canker Sores	❑	❑

ARTICULATION-MUSCLES		
Rheumatism	❑	❑
Osteoporosis	❑	❑
Arthritis	❑	❑
Artificial Joints	❑	❑
Jaw Problems / TMJ	❑	❑
Pain in Jaw	❑	❑

TREATMENT		
Chemotherapy	❑	❑
Radiation Treatment	❑	❑
Cortisone Treatment	❑	❑
X-ray or Cobalt Treatment	❑	❑

8) Do you have any disease or condition not listed? ☐ No ☐ Yes, explain: _____

9) Do you use tobacco? ☐ Yes ☐ No How much?_____ Are you using recreational drugs? ☐ No ☐ Yes, explain: _____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor, or his staff, at the next appointment without fail.

Signature:_____ Date:_____ Dentist/Hygienist Signature: _____

MEDICAL UPDATES

I have reviewed my Medical Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____

PATRICK T. YOSHIKANE D.D.S.

General, Aesthetic and Implant Dentistry

Patient-Dentist Arbitration Agreement, and Confidentiality and Non-Disparagement Agreement

Article I.

I, the undersigned, understand, acknowledge and agree that any dispute as to any alleged dental malpractice, or any claim as to whether any dental services rendered under this contract were unnecessary, unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California Law, and not by a civil lawsuit, or court process, except as California law provides for judicial enforcement of arbitration proceedings. Both parties of this contract by entering into it, have given up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

NOTICE: Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:
The term "patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:
Patient understands and agrees that any dispute of the sort described in Article I between doctor and patient will be subject to the terms of this Agreement, including, but not limited to, compulsory, binding arbitration. Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort described in Article I as to dental treatment rendered in or affecting the unborn child will be subject to the terms of this Agreement, including, but not limited to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes:
In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing.

B. Method of Initiating Arbitration:
If the dispute is not resolved by mutual Agreement within ninety (90) days. Patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS (Judicial Arbitration and Mediation Services) Orange County, whereby JAMS provides a list of 10 potential arbitrators, and the parties hereto will have ten (10) days to list the order of preference of such arbitrators. The administrator will then select the arbitrator, based upon the combined preference of the parties. The arbitrator must be selected within thirty (30) days of the notification to JAMS of the matter; and the arbitration must be completed within six (6) months.

C. Applicable Law:
The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 (and the recovery limits set forth therein) which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.

D. Attorneys' Fees:
The prevailing party shall be entitled to attorneys' fees.

Article IV.

A. Revocation:
If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

Article V.

A. Confidentiality/Non-Disparagement:
Patient agrees that he/she will not make or cause to be made any statements that disparage or damage the reputation of Doctor. Patient also agrees that he/she will not encourage or incite other customers of Doctor to disparage or assert any complaint or claim, or to initiate any legal proceeding, against Doctor. In the event such a communication is made to any person or entity, including but not limited to, print and television media, social media (e.g., Yelp, Google, Facebook, Twitter, Instagram, YouTube), blogs, websites, internet postings, publishing companies and public interest groups, it will be considered a material breach of the terms of this Agreement. Patient acknowledges and affirms that damages from such breach will be difficult to determine, and as such, Patient agrees to liquidated damages, in the amount of ten times the charges for all the dental work provided.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE GIVING UP CERTAIN LEGAL RIGHTS, BY AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT.

PATIENT'S NAME: (Please print):_____ DATE:_____

SIGNED:_____
(If Patient is a minor, the Legal Guardian's Signature)

Batavia Woods Medical Center 845 West La Veta Ave. Suite 103 Orange, CA 92868
(714) 516-1608 • Fax (714) 516-1592 • www.patrickyoshikanedds.com

POS Reorder # 1810992

Patrick T Yoshikane DDS, Inc.
845 W La Veta Ave #103
Orange, CA 92868

Participant's Name: _____

I hereby authorize Patrick T Yoshikane DDS, Inc. to publish the video testimonials, photographs taken of me, and my name, for use in their printed publications, social media, and website.

I acknowledge that since my participation in publications, social media and websites produced by Patrick T Yoshikane DDS, Inc. is voluntary, I will receive no financial compensation.

I further agree that my participation in any publication, social media, or website produced by Patrick T Yoshikane DDS, Inc. confers upon me no right of ownership whatsoever.

I release Patrick T Yoshikane DDS, Inc., its contractors, and its employees from liability for any claims by me or any third party in connection with my participation.

Signature: _____ Date: _____

Street Address: _____

City, State, Zip: _____

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA–Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your heath information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Protecting Your Confidential Health Information is Important to Us

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI: and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Patient Acknowledgment

Patient Name(s):_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date _____/_____/_____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Patient Acknowledgements and Authorizations

Patient Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment American Express, CareCredit, Lending Club, Master Card, Visa.
*Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our practice is a contracted as a PPO Premier provider with Aetna, Cigna, and Delta Dental benefit plans.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this. _____(initial)

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service. _____ (initial)

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of **$75.00** or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule and appointment if a patient is 15 minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of **$75.00** or deposit to reserve the appointment time again, may be required.

PLEASE NOTE: Sedation and/or Surgical services cancelled or rescheduled with less than seventy-two (72) business hour notice will result in a 50% charge of the scheduled services.

Patient Authorizations

I understand that the information I have given today is correct to the vest of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (circle one) _____ (initial)

Patient Communication

Voice Messages:

I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my house unless I have provided the practice with alternate instructions for communication. _____ (initial)

Text:

I consent to receive information and appointment reminders via text. Dr. Yoshikane will use the minimum necessary amount of protected health information in any communication. _____ (initial)

Patient's emailed request for information: We are happy to respond to your query. Our office uses unencrypted email. You have the right to request to receive your information via unencrypted email. In order for us to send your information to you via unencrypted email, you must provide your consent, recognizing that unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. We will use the minimum amount of protected health information necessary to respond to your query. If you wish to conduct this discussion via unencrypted email, pleased indicate your acceptance of this risk with your email reply. You may withdraw your consent at any time. Alternatively, please contact our office to arrange a telephone conversation or office visit if you decide against corresponding via email. _____ (initial)

- **Act on a verbal request from the patient:** Please email your request to our office. (Then the office can respond as described above, or the dentist or HIPAA privacy officer can discuss with the patient the risk of unsecured email and document the conversation and consent in the patient record.) _____(initial)

Patient Acknowledgements

I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** had been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)

Cellphone:

I consent to the dental practice using my cellphone number to call or text regarding appointments and treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cellphone number is (include area code):

(_____) _____ _____(initial)

_____

Patient Signature Date

I **Do Not** consent to receiving any information via email or text. I understand that I can change my mind and provide consent later. _____

Patient Signature Date