

Bridgeview Dental Associates

John N. Briles, D.M.D.

Stuart K. Parks, D.M.D.

Whom may we thank for referring you to our office? _____

Confirmation of Appointments: Depending upon the type of appointment, it is our office policy to give patients a courtesy phone reminder of upcoming appointments as well as reminder postcards for upcoming hygiene appointments. Frequently, we need to leave messages or reminders on answering machines, voice mail, email, or with persons other than the patient. By affixing your signature below, you allow the staff of Bridgeview Dental Associates to leave messages and/or confirmations of your appointments on the above referenced communication systems and/or with persons other than yourself.

Signature: _____

Privacy Practices: We are required by applicable federal law to maintain the privacy of your health information. We are also required to give you a Notice about our privacy practices, our legal duties, and your right concerning your health information. We must follow the privacy policies that are described in this notice while it is in effect. This Notice took effect on 04/14/2003, and remains in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact our office manager. Your signature below indicates that we have made our Notice of Privacy Practices available to you.

Signature: _____

I understand that the information I have given is correct to the best of my knowledge, and will be held in the strictest confidence. I authorize the staff of Bridgeview Dental Associates to perform any necessary dental services during diagnosis and treatment with my informed consent. I hereby authorize my insurance benefits to be directly paid to Bridgeview Dental Associates, and agree that I am financially responsible for non-covered services. I also authorize the release of any information requires to process insurance claims. Bridgeview Dental Associates reserves the right to verify the credit status of patients and/or parents of patients prior to extending credit for treatment fees and may use the services of one or more credit reporting services.

Signature: _____