Financial Policy

Dear Patient,

We would like to take this opportunity to thank you for choosing us as your health care provider. Our goal is to be devoted and available at all times to answer your questions and alleviate your concerns. We are dedicated to providing you with the most personalized and the highest quality of care. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to your treatment.

INSURANCE PATIENTS:
Prior to your scheduled visit we recommend that you verify your insurance benefits with your insurance company. Authorization or verification from your insurance carrier (written or verbal) is not a guarantee of payment. We will collect the required prepayment percentage, co-pay and deductible of the ESTIMATED charges at the time of treatment regardless of the assignment of benefits. The balance on your account is your responsibility whether the insurance company pays or not. We will bill your insurance company as a courtesy to you; therefore, we require that you supply us with all appropriate forms and information such as telephone numbers and addresses regarding your insurance company. In the event inaccurate information is obtained, making it impossible to bill the claim, the account will become your responsibility and payable in full within 30 days from the date of service. If applicable e.g. where a prior approval is required, it is the patient’s ultimate responsibility to ensure all procedures are approved by the policy holder’s insurance company.

Participating Provider Insurance Companies:
We accept most major insurance programs and participate in many local Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). All HMO patients cannot be seen without the proper referral. These have to be obtained from your Primary Care Physician (PCP). We will deduct any contractual discounts, if any, as stated by our contract with your insurance company. All co-payments, deductibles and any percentages established by your insurance plan are due at the time of service.

Non-Participating Provider Insurance Companies:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. There is not contractual discount between our doctors and your insurance company. All co-payments, deductibles and any percentages established by your insurance plan are due at the time of service.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. If your insurance company pays below our fee schedule, you are responsible for any unpaid balance regardless of your insurance company’s arbitrary determination of usual and customary rates. If you are dissatisfied with the benefits paid by your insurance you have the right to appeal to your insurance company for additional reimbursement.

SELF-PAY PATIENTS:
Full payment will be expected at the time of service. We accept Visa, MasterCard. Discover/Novus, check with proper identification and cash. If any of these methods are not convenient for you, Care Credit, and independent credit company, can finance your care on approved credit. This will allow you to start your treatment today and make payments over time.

MINORS:
No minor will be seen without a parent or a legal guardian present. In the situation of a divorce, we will bill the insurance on file. If there are any balances due, the person signing the Financial Policy will ultimately be responsible for the balance.

DOCUMENT FEES
There is a $35 fee for completion of FMLA and Disability forms. The fee must be paid in advance.

We will charge a rebilling fee of 2% for each month on all unpaid balances over 30 days. Balances under $100.00 will be charged a minimum of $2.00 per month.

There will be a $25.00 service charge on all returned checks.

Please note: if your account is turned over to Transworld/Collections you will be charged a $20.00 processing fee.

Due to the personalized ordering process for dental implants there is a $400.00 deposit per implant. There will be a 20% restocking fee per implant for any canceled dental implant procedure.

Please understand that payment of your bill is part of your treatment. We feel that the above explanations in regard to our policies will assure that we will preserve the best possible relationship with our patients. Please let us know if you have any questions or concerns. We would be more than happy to assist you.

I have read, understand and agree to the provisions of the Financial Policy.

__________________________________________  ________________________________
Signature of patient and/or person financially responsible                     Date

_________________________  ________________________________
PATIENT COPY  Oral & Maxillofacial Surgery Associates of Nevada • www.facialssurgery.org Page 1 of 10
Financial Policy

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I have read, understand and agree to the provisions of the Financial Policy.

Signature of patient and/or person financially responsible

Date

rev_01262019_MEL/RG Oral & Maxillofacial Surgery Associates of Nevada • www.facialsurgery.org
PATIENT INFORMATION

Phone ___________________________ Today's Date ________________

Name ___________________________ Soc. Sec. # ________________
  Last Name __________ First Name __________ Middle Initial __________

Address _____________________________________________________________

City ___________________________ State __________ Zip, __________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Sex: ☐ M ☐ F Age _____ Birthday __________

Reason for today's visit? _____________________________________________

Patient Employed By ___________________________ Occupation __________

Business Address ___________________________ Business Phone __________

Who should we thank for your referral? ________________________________

Okay to call work? ☐ Y ☐ N ☐

In case of emergency, who should be notified? Name ___________________________ Phone __________

Primary Physician ___________________________ Phone __________

Address _____________________________________________________________

Dentist ___________________________ Phone __________

Address _____________________________________________________________

PRIMARY INSURANCE

Insurance Company ___________________________ Name ___________________________ Phone __________

Group # ___________________________ Member # ___________________________

Name of Insured ___________________________ Last Name __________ First Name __________ Middle Initial __________

Relation to Patient ___________________________ Birthdate __________ Soc. Sec. # __________

Address (if different from patient) ___________________________ Phone __________

City ___________________________ State __________ Zip, __________

Person insured employed by ___________________________ Occupation ___________________________

Business Address ___________________________ Business Phone __________

Okay to call work? ☐ Y ☐ N ☐

Does this insurance cover: Medical: ☐ Y ☐ N Dental: ☐ Y ☐ N Both: ☐ Y ☐ N

If your insurance does not cover both medical and dental benefits, please provide insurance information for your separate dental or medical plan on the next page.
Insurance Company __________________________ Name __________________________ Address __________________________ Phone __________________________

Group # __________________________ Member # __________________________

Name of Insured __________________________________________ Last Name __________________________

Relation to Patient __________________________ Birthday __________________________ Soc. Sec. # __________________________

Does this insurance cover: Medical: □ Y □ N Dental: □ Y □ N

SECONDARY INSURANCE

Is patient covered by additional insurance? □ Y □ N __________________________

Insured Name __________________________ Relation to Patient __________________________ Birthday __________________________

Address (if different from patient) __________________________ Phone __________________________

Member's Employer __________________________ Occupation __________________________ Business Phone __________________________

Okay to call work? Y □ N □ __________________________

Insurance Company __________________________ Name __________________________ Address __________________________ Phone __________________________

Group # __________________________ Member # __________________________

Does this insurance cover: Medical: □ Y □ N Dental: □ Y □ N Both: □ Y □ N

ACCIDENT RELATED INJURIES

Is this visit related to an Accident? Auto: □ Y □ N Work Related: □ Y □ N Other: □ Y □ N __________________________

Date of Injury ____________ Insurance Company __________________________ Phone __________________________

Claim # __________________________ Name of Case Worker/Adjuster __________________________

Name of Attorney __________________________ Phone __________________________

Please Read and Sign Below and Return Form to Receptionist

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with __________________________ Name of the Insurance Company(s)

and assign directly to Dr. __________________________ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

__________________________ __________________________ __________________________

Responsible Party Signature Relationship Date

Approved by:

Date:

Oral & Maxillofacial Surgery Associates of Nevada • www.facialsurgery.org
Mark L. Glyman, M.D., D.D.S., F.A.C.S.  
Eric D. Swanson, M.D., D.M.D., F.A.C.S  
2030 E. Flamingo Rd., Ste. 288 • Las Vegas, NV 89119 • Office (702) 892-0833 • Fax (702) 892-0906  
1775 Village Center Circle, Ste. 150 • Las Vegas, NV 89134 • Office (702) 507-5555 • Fax (702) 946-1300

MEDICAL HISTORY  
(Please Print)

Please answer the following questions.

Patient Name ___________________________ Last Name ________ First Name _______ Middle Initial ______

Are you in good health? Y ☐ N ☐ Height __________ Weight __________

Have there been any changes in your general health in the past year Y ☐ N ☐

If so, for what are you being treated? _____________________________________________

Have you had any illness, operation or been hospitalized in the past five years? Y ☐ N ☐

Do you have any unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so, describe where. _____________________________________________

Do you have a prosthetic joint/implant? Y ☐ N ☐ If so, describe where: _____________________________________________

Have you had a heart valve replacement or vascular graft? Y ☐ N ☐

Have you ever been diagnosed with HIV/AIDS? Y ☐ N ☐

Are you claustrophobic? Y ☐ N ☐

<table>
<thead>
<tr>
<th>Have You Had Or Do You Currently Have:</th>
<th>Yes</th>
<th>No</th>
<th>Have You Had Or Do You Currently Have:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rheumatic Fever</td>
<td></td>
<td></td>
<td>28 Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Damaged Heart Valves/Mitral Valve Prolapse</td>
<td></td>
<td></td>
<td>29 Thyroid Trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Heart Murmur</td>
<td></td>
<td></td>
<td>30 Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 High Blood Pressure</td>
<td></td>
<td></td>
<td>31 Low Blood Sugar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Low Blood Pressure</td>
<td></td>
<td></td>
<td>32 Kidney Trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Chest Pain, Angina</td>
<td></td>
<td></td>
<td>33 Are You On Dialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Heart Attack(s)</td>
<td></td>
<td></td>
<td>34 Swollen Ankles, Arthritis Or Joint Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Irregular Heart Beat</td>
<td></td>
<td></td>
<td>35 Stomach Ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Cardiac Pacemaker</td>
<td></td>
<td></td>
<td>36 Contagious Diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Heart Surgery</td>
<td></td>
<td></td>
<td>37 Sexually Transmitted Diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Bronchitis, Chronic Cough</td>
<td></td>
<td></td>
<td>38 Problems With The Immune System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Asthma</td>
<td></td>
<td></td>
<td>39 Delay In Healing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Hay Fever/Sinus Problems</td>
<td></td>
<td></td>
<td>40 A Tumor Or Growth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Tuberculosis</td>
<td></td>
<td></td>
<td>41 X-ray Treatment/Chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Persistent Cough</td>
<td></td>
<td></td>
<td>42 Bloody Sputum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Unexplained Weight Loss</td>
<td></td>
<td></td>
<td>43 Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Emphysema</td>
<td></td>
<td></td>
<td>44 Chronic Fatigue/Night Sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Difficult Breathing/Other Lung Trouble</td>
<td></td>
<td></td>
<td>45 Are You On A Diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Do You Smoke</td>
<td></td>
<td></td>
<td>46 A History Of Drug Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Blood Transfusion</td>
<td></td>
<td></td>
<td>47 A History Of Alcohol Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Blood Disorder Such As Anemia</td>
<td></td>
<td></td>
<td>48 Contact Lenses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please continue on second page
<table>
<thead>
<tr>
<th>Question</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruise Easily</td>
<td>22</td>
</tr>
<tr>
<td>Bleeding Tendency (Abnormal Bleeding)</td>
<td>23</td>
</tr>
<tr>
<td>Jaundice Hepatitis Or Liver Disease</td>
<td>24</td>
</tr>
<tr>
<td>Infectious Mononucleosis</td>
<td>25</td>
</tr>
<tr>
<td>Gallbladder Trouble</td>
<td>26</td>
</tr>
<tr>
<td>Fainting Spells</td>
<td>27</td>
</tr>
<tr>
<td>Eye Disease/Glaucoma</td>
<td>49</td>
</tr>
<tr>
<td>Mental Health Problems</td>
<td>50</td>
</tr>
<tr>
<td>A Removable Dental Appliance</td>
<td>51</td>
</tr>
<tr>
<td>Pain &amp; Clicking Of Jaws When Eating</td>
<td>52</td>
</tr>
<tr>
<td>Malignant Hyperthermia</td>
<td>53</td>
</tr>
<tr>
<td>Convulsions, Epilepsy</td>
<td>54</td>
</tr>
</tbody>
</table>

If you are having surgery today, please answer the next two questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had anything to eat or drink in the last 8 hours?</td>
<td>55</td>
</tr>
<tr>
<td>Who is driving you home today?</td>
<td>56</td>
</tr>
</tbody>
</table>

**MEDICATION**

<table>
<thead>
<tr>
<th>Are You Now Taking:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>57. Any Kind Of Medicine, Drugs, Or Pills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58. Anticoagulants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59. Diet Pills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60. Tranquilizers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>61. Steroids</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ALLERGIES**

<table>
<thead>
<tr>
<th>Are You Allergic To Or Had A Reaction To:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>63. Local Anesthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64. Penicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65. Other Antibiotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>66. Sodium Pentothal, Valium, Or Other Tranquilizers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>67. Aspirin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>68. Codeine Or Other Narcotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>69. Other Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70. Allergies Other Than Drug Allergies? (Please List Below):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**WOMEN**

<table>
<thead>
<tr>
<th>Please Answer The Following:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>71. Is There A Possibility Of Pregnancy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>72. Estimated Delivery Date <em>/__/</em>___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>73. Are You Nursing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>74. Are You Taking Birth Control Pills?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Is There A Family History Of:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>75. Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>76. Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77. Is there any condition concerning your health that the doctor should know about?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please Describe:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I certify that I have read and understand all the questions answered above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my knowledge. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

<table>
<thead>
<tr>
<th>Name Of Patient/Parent/Guardian</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician Signature: __________________________ Date: ________________
Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (Including direct or indirect treatment by other healthcare providers)
- Obtaining payment from third-party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from the time to time and I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care options but you are not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoked the consent is not affected.

Signed this ______ day of _____________________, 20_____.

Print patient Name: __________________________________________

Relationship to Patient: _______________________________________

Signature: ___________________________________________________
Confidentiality Form

Please understand that it is the goal of this office to ensure that our patient's privacy is held in the strictest confidence. Please carefully read the following information:

The purpose of this form is to give authorization to family, friends or legal guardian to discuss your medical/surgical status such as: Date of service, medications, complications, diagnostic testing or any questions to assist in your care and treatment.

Much of the information will be by telephone conversation with the doctor, nurse, front office personnel or surgery scheduling department. Authorized persons will be required to have a "CODE" number. The code will be last four digits of your social security number. If the person inquiring about you does not have the code "CODE" number no information will be released via telephone, fax or mail.

Please list name(s) and relationships of ALL persons authorized. If no person is to be given this information, write “ALL PERSONS DENIED”. For your security, failure to provide any information or providing incomplete information will constitute “all persons denied”. Thank you.

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

______________________________  ____________________________
Patient/Guardian Signature                  Date

______________________________  ____________________________
Patient/Guardian Signature                  Date
Patient Pharmacy Information

We are utilizing Electronic prescribing for prescriptions whenever possible.

We need your pharmacy information to update our system. Please fill out the information below:

Patient Last name: ___________________________ First Name: ___________________ Middle Initial: _____

Date of Birth: ___________________________

Local Pharmacy Name: ___________________________

Pharmacy Phone Number: ___________________________

Pharmacy address: ___________________________

(If not known, please give major cross streets e.g. "Walgreens at Main and Washington")
Consent for release of medical records

Date: ____________________________

I, ____________________________, hereby consent and authorize the office of Mark L. Glyman, M.D., D.D.S., and Eric D. Swanson, M.D., D.M.D., to release copies of my medical records including, but not limited to, laboratory reports, x-rays, and any other materials regarding medical consultations and treatments that I have received, including copies of current and previous medical records from other practices and practitioners, hospitals, and/or clinics.

My records should be under the following name:

Last name: ____________________________ First Name: ____________________________ Middle Initial: _____

Date of Birth: ____________________________

Current Address:

Number Street Suite/Apartment/unit (if applicable)

City: ____________________________ State: ____________________________ ZIP: ____________

Please specify (INITIAL) to whom you wish to release your medical records (Select ONE):

_______ I am requesting a copy of my medical records ONLY FOR MYSELF

_______ I am requesting a copy of my medical records FOR MYSELF AND THE INDIVIDUAL/ENTITY LISTED BELOW

_______ I am requesting a copy of my medical records ONLY FOR THE INDIVIDUAL/ENTITY LISTED BELOW

All necessary medical records including account information can be released to the following individual(s)/entity:

Name: ____________________________

Address:

Number Street Suite/Apartment/unit (if applicable)

City: ____________________________ State: ____________________________ ZIP: ____________

Name: ____________________________

Address:

Number Street Suite/Apartment/unit (if applicable)

City: ____________________________ State: ____________________________ ZIP: ____________

Patient/Guardian Signature ____________________________ Date ____________________________

OFFICE USE ONLY

Verified By: ____________________________ Date: ____________________________

Verification Method: ____________________________ (DL/PASSPORT/ID ETC.)
UPDATED/CURRENT INFORMATION FOR APPOINTMENT CONFIRMATION, ETC.

PATIENT NAME: ____________________________________________

PATIENT DOB: _____________________________________________

PATIENT CELL PHONE NUMBER: _______________________________

PATIENT E-MAIL ADDRESS: ___________________________________