Melvin L. Matsuda, DDS, PC
Michael L. Matsuda, DDS

Hillsboro Implants & Periodontics
363 SE 4th Avenue Hillsboro, OR 97123
503-640-1313

PATIENT INFORMATION

Name_____
Last First Middle Initial

Address_____

City_____State_____Zip Code_____

Cell Phone:_____Work Phone:_____Home Phone:_____

Birthdate_____Social Sec #_____ Email:_____

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

Responsible Party Information (If Under age 18)

Name_____
Last First Middle Initial

Mailing Address_____
Street City State Zip

How long at this address?_____Home Phone_____Work Phone_____

Social Sec. #_____Birthdate_____Relationship to Patient_____

Primary or Secondary Insurance Holders Information (if different than patient)

Name_____Relationship to Patient_____
Last First M.I.

Employer_____Occupation_____

Social Sec. #_____Birthdate_____Work Phone_____

Dental Insurance Information

Primary Insurance

Name of Company_____
ID #:_____Local #_____
Group #:_____

Secondary Insurance

Name of Company_____
ID #:_____Local #_____
Group #:_____

Terms and conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed.

I understand that dental services furnished to me are directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help me prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

There is a $30.00 service fee on all returned checks. NSF checks must be redeemed with certified funds (cashier's check, money order, certified check or cash).

Assignment of Insurance: I hereby authorize release of any information needed and also authorized my insurance company to pay directly to this office benefits accruing to me under this policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

X_____
Patient or Guardian's Signature Date Guardian's relationship to Patient

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Financial Policy

To our Valued Patients,

Welcome to our family of patients. At Hillsboro Implants & Periodontics we strive to achieve optimal oral health and care for you. We partner with our patients to help you achieve the smile you deserve!

Insurance Notice: As a courtesy to our patients, we are happy to bill your dental insurance to receive the dental benefits you and your employer are paying for. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amount that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

Medical Insurance: Our office does not bill medical insurance. If you believe you have coverage through your medical plan, we will collect the full amount for treatment and provide you with any documentation you may need to bill your medical insurance for reimbursement.

Treatment plans: They are only an ESTIMATE of charges. It is subject to modification depending on unforeseen or un-diagnosable circumstances that may arise during treatment. Patients with dental insurance: We bill your insurance as a courtesy. Delinquent accounts will be charged a finance charge of $5.00 or 1.5% per month whichever is greater.

We collect your out-of-pocket portion at the time of surgical treatment. Treatment plans are NOT an estimate of insurance coverage. Until we get a preauthorization in writing from your insurance we are not aware of what your insurance will cover or pay. If you come in prior to our office getting the preauthorization back for treatment we collect a baseline amount of anything over $1200 or 20% whichever is greater. If you do not have insurance your balance is due, in full, the day of your appointment. We offer a 5% cash or check discount off your out of pocket, for any surgical procedures only, **does not apply to debit cards.

Surgical Appointments: **We require a $100 sterilization and materials deposit to schedule all surgical appointments.** This deposit will be put towards your payment for services rendered at your appointment. (We reserve the right to keep this deposit should the patient not show for treatment or cancel with less than 48 hour notice per our cancelation policy.)

Cancelation Policy: We ask that if you need to cancel a scheduled appointment that you kindly give us 48 hour notice. Drs. Mel and Michael and the entire team spend valuable preparation time arranging every aspect for your visit. We reserve your appointment time in our schedule so we are able to give your treatment the detail it deserves. Less than 48 hour notice puts a great deal of strain on the entire team who then try and fill your reserved time. With respect to the team that serves you and the other patients who depend on us, we appreciate timely cancellation notifications and alerts if you are running late. We reserve the right to charge a $100 fee for any surgical appointment and a $50 fee for any other appointment type that is canceled with less than 48 hour notice or if you are to not show for your appointment.

I acknowledge that I have read the above office policies of Hillsboro Implants & Periodontics. I hereby authorize payment directly to Dr. Matsuda of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

Sincerely,
Hillsboro Implants & Periodontics

X_____

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NOTICE OF PRIVACY PRACTICES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home.

I wish to be contacted in the following manner: (check all that apply)

☐ Best Telephone:_____
- ☐ O.K. to leave detailed message
- ☐ Leave message with call-back number

☐ Work Telephone:_____
- ☐ O.K. to leave detailed message
- ☐ Leave message with call-back number

☐ Written/Oral Communication:
- ☐ O.K. to mail to home address
- ☐ O.K. to mail to work address
- ☐ O.K. to speak with spouse

☐ Other:_____

By signing below, I agree that I have received or been offered a copy of this office's Notice of Privacy Practices.

_____ _____
Print Patient Name Birth Date

X_____ _____
Patient or Guardian's Signature Date Guardian's relationship to Patient

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)_____

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NOTICE OF PRIVACY PRACTICES

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

I understand that Hillsboro Implants & Periodontics (referred to below as "the office") will use and disclose health information about me in the course of providing dental care to me.

I understand that my health information may include information both created and received by the office, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the office is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to/or consult and coordinate with other dental/health care providers in the course of my treatment;
- Determine my eligibility for dental plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my dental care
- Perform various office, administrative and business functions that support the office's ability to provide me with the appropriate care and arrange for payment.

I understand that uses and disclosures of private health information (PHI) for marketing purposes and disclosures that constitute a sale of PHI require and my written authorization. I understand my right to restrict certain disclosures of PHI to health plans if I pay out of pocket for the full cost of services at the time of service.

I understand it is my right to be notified of a breach of unsecured PHI if I am affected by such of breach.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the office's Notice of Privacy Practices in effect will be posted in the office.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the office is not required by law to agree to such requests.