NORTHLAND ORAL & MAXILLOFACIAL SURGERY
CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. *PLEASE REVIEW IT CAREFULLY.*

This notice applies to the medical records that are generated by this office. We have listed some of the reasons why we might use or disclose the information. Not every use or disclosure is covered, but all of the ways that we are allowed to use and disclose the information will fall into one of the categories. If you have questions about the content of this Notice or you need to contact someone at NOMS, the contact person is: **Gary L. Nesslein, D.D.S., M.D. at 816-452-0300**

**Use and disclosure of Medical Information the Requires Your Consent:**

We can disclose medical information about you regarding treatment and payment for services if we have your consent. If you do not give us permission to use or disclose your medical information, we do not have to treat you.

FOR TREATMENT: To provide you with medical treatment, we may need to disclose information about you to doctors, or their personnel who are involved in your treatment. Unless requested otherwise, we may also disclose medical information about you to people who may be involved in your medical care such as home health agencies and your family.

FOR PAYMENT: We may disclose your medical information from our office to bill and receive payment for the treatment you received at our office. We may also ask you insurance company for prior authorization for a service to determine benefit coverages.

FOR HEALTH CARE OPERATIONS: We can disclose medical information about you for health care operations. These include disclosures that are necessary to run our office and make sure that our patients receive quality care.
I consent to NOMS contacting me via voice, email or text regarding my patient care.

USES AND DISCLOSURES OF MEDICAL INFORMATION THAT **DO NOT** REQUIRE YOUR CONSENT: We can use or disclose health information about you without your consent when there is an emergency or when we are required by law to treat you, when we are required by law to disclose certain information, or when there are substantial communication barriers to obtaining consent from you. Additional reasons for disclosing information without specific consent are available to you at the front desk.

PLANNED DISCLOSURES TO WHICH YOU MAY OBJECT:

- We may disclose your health information to contact you and remind you of an appointment for treatment and/or medical care.
- We may release health information about you to a friend or family member who is involved in your care.
- We can tell your family or friends of your condition and that you are in our office for treatment. We can also give this information to someone who is helping to pay for your medical care.

If you have objections, please address them in writing to Dr. Gary L. Nesslein at 6301 North Oak Trafficway in Gladstone, MO 64118

I authorize Northland Oral and Maxillofacial Surgery to disclose information regarding my medical care to the following friends or family members:

_____

I HAVE RECEIVED AND REVIEWED THE CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION.

| Signature of Patient | Signature of Representative | Relationship | Date |
|---|---|---|---|

# Northland Oral and Maxillofacial Surgery

## REGISTRATION FORM

(Please Print)

## PATIENT INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| Patient's last name: First: Middle: | | | ❑ Mr ❑ Mrs. | ❑ Miss ❑ Ms. | Marital Status: Single ❑ Mar ❑ Div ❑ Sep ❑ Wid ❑ | |
| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | | Birth date: | Age: | Sex: ❑ M ❑ F |
| Street address: | | City: | | State: | Zip: | |
| Social Security Number: | Home Phone: ( ) | | Cell Phone: ( ) | | | |
| Occupation: | Employer: | | Employer phone no.: ( ) | | | |

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

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| **Name of Primary Dental Insurance:** | | | | | |
| Subscriber's name: | Subscriber's S.S/I.D. #: | Birth Date: | Employer: | Group no.: | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |
| **Name of Secondary Dental Insurance:** | | | | | |
| Subscriber's name: | Subscriber's S.S/I.D. #: | Birth Date: | Employer: | Group no.: | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |
| **Name of Medical Insurance:** | | | | | |
| Subscriber's name: | Subscriber's S.S/I.D. #: | Birth Date: | Employer: | Group no.: | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |

**FEES & PAYMENTS**

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney's fees, and court costs.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

I authorize my surgeon and his / her designated staff, to perform an examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

**X** _____ **X** _____

**Signature of patient** (Parent or Guardian if Minor) Date

Revised 09/13