Bonar Family Dentistry, LLC.

Patient Information Form

Patient Name: _____ Date of Birth: _____ Marital Status: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Cell: _____ Work: _____ Other: _____
E-mail: _____Driver's License #: _____ Social Security #: _____
Emergency Contact: _____ Relationship to Patient: _____ Phone: _____
Primary Care Physician: _____ Phone #_____

Insurance Information

Patient Employer: _____ Occupation: _____Work #: _____
Primary Dental Insurance: _____ Phone: _____
Subscriber Name: _____Patients Relationship to Subscriber: _____
ID#: _____ Group#: _____ Group Name: _____
Secondary Dental Insurance: _____ Phone: _____
Subscriber Name: _____Patients Relationship to Subscriber: _____
ID#: _____ Group#: _____ Group Name: _____

Responsible Party

Person Responsible for bill: _____ Home Phone: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Authorization and Release

I hereby authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such work to third party payers and or health practitioners. I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services, deductibles, and co-insurance. I understand that my insurance carrier may pay less than the actual bill for services. I authorize the physician to release any information required in processing of this claim and all future claims.

I acknowledge that I am financially responsible for the timely payment of my outstanding bill per payment policies I understand that my portion of the balance is due at the time of service. If I do not have insurance the full balance is due at the time of service. The undersigned agrees that unpaid balances over 90 days will receive finance charges of 1 ½ (one and one half) % per month (18%APR). If it becomes necessary to effect collection of any amount owed on this or subsequent visits, the undersigned agrees to pay any and all collection agency fees up to 50% of the amount placed with the collection agency. In the event that legal action must be taken for collections on your accounts, the undersigned will also be responsible for any and all fees associated with court costs, garnishment, and/or attorney fees.

Signed: _____ Date: _____

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HIPAA Policy

You may refuse to sign this acknowledgement

By signing below, I acknowledge that I have received a copy of Bonar Family Dentistry, LLC.'s Notice of Privacy Practices.

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**
- **Communications barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **A medical condition prohibited obtaining the acknowledgement**
- **Patient is under 18 and unable to sign for themselves**

Cancellation Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone and we do our best to accommodate your scheduling needs. When you make an appointment, please be sure that you will be able to keep it. It is our policy that you call as soon as you are aware you may not be able to make an appointment we require at the very least 24 hours' notice.

Like many offices, this office does call, text, and email to confirm your appointment. There will be a charge of $0 for the first, $25 for the second, $50 for the third and $75/possible dismissal for the fourth No Show, broken or cancelled appointments with less than 24 hours' notice. We do understand that sometimes you are unable to give 24 hours' notice and will take each situation in to consideration.

If you find you need to cancel or reschedule an appointment please call 503-581-4615, E-mail dentist@bonarfamilydentistry.com, or reply to your confirmation text and we will respond to you as soon as we are in the office to do so.

By signing below, I understand that Bonar Family Dentistry, LLC. requires 24 hours' notice if you I unable to make an appointment and that I will be charged for missing more than one appointment without adequate notice.

Patient Name: _____ Signature: _____ Date: _____