CHERI C. BLOOM DDS

815 West Canfield Avenue
Coeur d'Alene, ID 83815
(208) 762-2544 FAX (208) 762-9563

Thank you for trusting us with your dental health. We promise to do our best to provide you with the finest care available.

DENTAL REGISTRATION

PATIENT INFORMATION			
Last Name:		**First Name:**	**Initial:**
Preferred Name:	**DOB:**	**SS #:**	**Marital Status:**
Address:			
Home Phone:	**Employer:**		
Work Phone:	**Occupation:**		
Cell Phone:	**Emergency Contact:**		
E-mail Address:	**Emergency Phone:**		
How may we contact you – check ALL that apply: ☐ **Text** ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone** ☐ **E-mail**			
How did you hear about our office?			

RESPONSIBLE GUARANTOR INFORMATION			
Last Name:		**First Name:**	**Initial:**
Relationship to Patient:	**DOB:**	**SS#:**	
Address:			
Home Phone:	**Work:**	**Cell:**	
Employer:			

INSURANCE INFORMATION		
Primary Insurance Name:		**Group/Policy #**
Subscriber Name:	**DOB:**	**Subscriber/Member ID #:**

TREATMENT AUTHORIZATION, AGREEMENT TO PAY, INSURANCE ASSIGNMENT & RELEASE OF INFORMATION CONSENT

I hereby authorize Dr. Cheri Bloom or a designated team member to perform the necessary services for an oral health diagnosis. Upon such diagnosis I authorize Dr. Bloom to perform all recommended treatment mutually agreed to by me, and to employ such assistance as is necessary to provide proper care. I understand that all treatment has some risks and that I have or will be informed by Dr. Bloom or her designee of these risks, and the importance of either pursuance or non-pursuance of the recommended treatment. I consent to the use of photos, xrays or other information to be used for my diagnosis, treatment, and/or insurance billing. In consideration of services rendered to me or my dependent(s) at Dr. Cheri Bloom's office I understand I am obligated to pay in accordance with their financial policies. If I or my dependent(s) are insured, I assign all insurance benefits directly to Cheri C. Bloom and hereby authorize her office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am financially responsible for all charges whether or not paid by insurance, and that I am required to give 24 hours' notice of cancellation. I consent to being contacted by phone, text or email unless otherwise indicated. I certify I have read the contents of this form.

I authorize Dr. Cheri Bloom's office to discuss my protected health information including treatment and account information with the following spouse, friend, or family member(s): _____

_____	_____	_____
Responsible Party Signature	**Date**	**Relationship to Patient**

NOTICE OF PRIVACY PRACTICES FOR CHERI BLOOM DDS

Revised 11/15/14

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, AND FOR OTHER PURPOSES PERMITTED OR REQUIRED BY LAW. IT ALSO DESCRIBES YOUR RIGHTS TO ACCESS, CONTROL, AND TO OBTAIN COPIES OF YOUR HEALTH CARE INFORMATION.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

Dr. Bloom and her staff are dedicated to protecting the personal information that patients entrust to us. We are required by law to maintain the privacy of our patients protected health information ("PHI"); to provide notice of our duties and privacy practices; to abide by the terms of this Notice of Privacy Practices currently in effect; and to notify affected individuals following a breach of unsecured PHI.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

We use and disclose the information we collect from you only as allowed by the HIPAA Privacy and HIPAA Security Rule. We will not use your information for marketing purposes without your written consent. Some information, such as HIV or mental health-related, may be entitled to special confidentiality under State or Federal laws, which we will abide by. We may use and disclose your health information for treatment, including sharing your information with a specialist; to obtain payment for your services, including billing insurance or someone else responsible for payment; and for health care operations necessary to run our practice. We may disclose health information when contacting you to remind you of appointments or needed treatment, either by postcard, letter, phone call, voice message, email and/or text messaging. We may disclose your health information to family members or others identified by you when they are involved in your care or payment for your services. We may use and disclose your health information to our "Business Associates" performing functions on our behalf such as labs or computer and practice management software technicians. All of our Business Associates are obligated, under contract with us, to protect your privacy and to only use your health information as specified in our contract. We are required to disclose patient health information to law enforcement to report child abuse or domestic violence, or in response to a court order or subpoena. We will disclose patient health information to the Secretary of the U.S. Department of Health & Human Services as required to determine our HIPAA compliance. Some other less common uses and disclosures of your health information may include: other public health activities such as disease prevention/control or to aid in disaster relief; government health oversight purposes such as monitoring the healthcare system; lawsuits that you are involved in or other legal actions; coroner, medical examiner or funeral director requests; worker's compensation proceedings; for research purposes pursuant to patient authorization waiver approval; for specialized government functions such as those involving national security or military personnel; and to correctional facilities or law enforcement having lawful custody of an inmate.

PATIENT RIGHTS

You can ask to see or receive a copy of your health information. Written requests are required and we can charge a reasonable fee for providing the information. We may deny your request under certain circumstance but you will receive a written response and can appeal our decision. You can receive copies of your health information in a variety of formats, including electronically. You can make reasonable requests to be contacted someplace other than home, and by specific methods. If you believe your health information is incorrect or incomplete, you may ask that we amend it or add information if you think something is missing. You can request restrictions on our use or disclosure of your information by submitting a written request. You can restrict us from disclosing to your insurance company any treatment that you elect to pay for in full out of pocket. You can request a list of instances in which we, or a Business Associate, have disclosed your protected information for uses other than stated above. You have the right to be notified by our office of any privacy breach in violation of HIPAA/HITECH through unauthorized acquisition, access, use or disclosure of protected information.

If you are concerned that we may have violated your privacy rights or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict its use, please contact us using the information listed below. You may also submit a written complaint to the U.S. Department of Health & Human Services; to learn more, visit www.hhs.gov/ocr/privacy. We will not retaliate in any way if you choose to file a complaint with us or with any government agency.

Our Privacy Official: Sue Paschall Dr. Cheri Bloom DDS 815 W. Canfield Avenue, Coeur d'Alene, ID 83815
Phone/Fax/Email: (208) 762-2544 FAX (208) 762-9563 EMAIL cheribloomdds@frontier.com

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR CHERI BLOOM DDS

You may refuse to sign this Acknowledgement. You may revoke this Acknowledgement at any time.

I acknowledge that I have received, reviewed or been offered a copy of the *Notice of Privacy Practices for Cheri Bloom DDS*.

_____ _____ _____

Patient Signature **Relationship to Patient** **Date**