Hudson Valley Dentistry
Gen Ohkawa, DDS, FICOI
33 Route 32A, Saugerties, NY 12477
Tel: (518) 678-3111 Fax: (518) 678-1137
www.HudsonValleyDentistry.com

Patient Name:
Last ______________ First ______________ Middle ______________
Date of Birth (MM/DD/YYYY): ____/____/______ SSN: ______________ Gender (circle one): F / M
Home Phone: (____) ______________ email: ______________
Cell Phone: (____) ______________
Work Phone: (____) ______________
Emergency Contact: Name ______________ Tel # (____) ______________
Home Address: ______________ City: ______________ ST: ______ Zip: ______
Mailing Address (if different): ______________
Marital Status (circle one): Single Married Divorced Separated Widowed
Student Status (circle one): Full-time Part-time
Occupation: ______________

Primary Insurance:
Dental Insurance Company: ______________
Member ID# ______________ Group # ______________
Insurance address: ______________ City: ______________ ST: ______ Zip: ______
Insurance Tel #: (____) ______________
Employer of Primary Insured: ______________ Work Tel: (____) ______________
Employer address: ______________ City: ______________ ST: ______ Zip: ______
Primary Insured Name: Last ______________ First ______________
Primary Insured DOB (MM/DD/YYYY): ____/____/______ Primary Insured SSN ______________
Relationship to patient (circle one): Self Spouse Child Domestic partner Dependent

Secondary Insurance (if any):
Dental Insurance Company: ______________
Member ID# ______________ Group # ______________
Insurance address: ______________ City: ______________ ST: ______ Zip: ______
Insurance Tel #: (____) ______________
Employer of Primary Insured: ______________ Work Tel: (____) ______________
Employer address: ______________ City: ______________ ST: ______ Zip: ______
Primary Insured Name: Last ______________ First ______________
Primary Insured DOB (MM/DD/YYYY): ____/____/______ Primary Insured SSN ______________
Relationship to patient (circle one): Self Spouse Child Domestic partner Dependent

Responsible Party for this account:
Name: ______________ Relationship to patient ______________
Address: ______________ City: ______________ ST: ______ Zip: ______
Home Phone: (____) ______________ Date of Birth (MM/DD/YYYY): ____/____/______
Cell Phone: (____) ______________ SSN: ______________

How did you hear about us? (circle one) Drive-by / Word of mouth / Internet / Advertisement ______________

Release and/or Transfer Records to Gen Ohkawa, DDS

Hudson Valley Dentistry
Gen Ohkawa, DDS
33 Route 32A
Saugerties, NY 12477
Tel (518) 678-3111

To Dr. ______________________________:

Address ____

Tel: _________________________________ Fax: ____________________________

Email: ____

I authorize the **release of all dental and/or medical records** relevant to dental treatment, or copies of such for the below patient(s), and request that they are **transferred to**:

Hudson Valley Dentistry
Gen Ohkawa, DDS
33 Route 32A
Saugerties, NY 12477
Tel (518) 678-3111
Fax (518) 678-1137
Email: hudsonvalleydentistry@gmail.com

Patient Name(s) ___________________________________

____

____

____________________________________ ______________________

Signature of patient, parent, or guardian Date

____

Name of signee

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patient Name: ____

Parent/Legal Guardian Name: ____________________________________

Relationship to Patient: ____

Signature: ______________________________ Date: ______________

Authorization and Consent to send Patient information via Unencrypted email and other electronic means

I authorize unencrypted electronic transmission of patient information relating to my treatment, health, or payment to me, someone I designate, other healthcare providers, health/dental plans (third party payer), and/or others involved in my treatment and/or payment for my treatment. Patient information that may be transmitted electronically may include x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment, and eligibility for benefits will not be affected by my decision about signing this form.
- If I do not sign this form, Gen Ohkawa, DDS may use other ways to send my information such as USPS mail, or may ask me to send my information to third parties myself.
- There are risks to unencrypted electronic transmission and information may be acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- Gen Ohkawa, DDS does not email information including Social Security number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless a patient requests in writing.
- I may discontinue this consent at anytime by giving written notice to Gen Ohkawa, DDS and if I do so, this will not affect the emails, facsimiles, and other electronic transmissions prior to receiving my written instructions to stop.

Patient Name (please print):______________________________ DOB____________

Signature of patient (or guardian, if applicable):______________________________

If Guardian, printed name of signee: ______________________________

Date: ________________

PATIENT FINANCIAL RESPONSIBILITY & NON-COVERED SERVICES ACKNOWLEDGEMENT FORM

Thank you for entrusting Dr. Gen Ohkawa, DDS as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies and non-covered services.

Patient Financial Policies

- The patient is ultimately responsible for the payment of his/her treatment and care.
- The patient is responsible for missed appointment charges as outlined in the fee schedule.
- The patient is responsible for any costs associated with collections of patient balances.
- Patient statements are mailed monthly. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency).

Non-Covered Services Acknowledgement

I, ___________________________ (print patient / guardian name), understand that the services performed by and/or supplies prescribed by Dr. Gen Ohkawa, DDS may not be considered eligible for benefits by my insurance carrier. I understand that my insurance coverage has certain restrictions, as well as non-covered services and supplies.

Nearly all dental benefit plans are the result of a contract between the plan sponsor (usually an employer or a union) and the third-party payer (usually an insurance company). The amount the plan pays is determined by the agreement negotiated by the employer with the insurer. Dental coverage is determined not by the patient's dental needs, but by how much the employer contributes to the plan.

If my dependent or I choose to receive the services and /or supplies prescribed by Dr. Gen Ohkawa, DDS and they are not covered by my insurance, I agree in advance to accept full financial responsibility for all costs associated with the non-covered services.

Patient Authorization

By my signature below, I hereby authorize assignment of financial benefits directly to Hudson Valley Dentistry, a.k.a. Gen Ohkawa, DDS PLLC, and associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. I have read, understand, and agree to the provisions of this form:

____ ______________

Signature of Patient or Guardian Date

Broken Appointment Policy

When a dental appointment is made in our office, a specific time is reserved for the patient to see the dentist or hygienist. We do not "double book" as many offices do. The appointment allows the dentist and hygienist to meet the patient's needs and also schedule other equally important patients. Broken appointments result in a loss of valuable time that could be spent with patients in need of treatment and they are very costly to our office.

For this reason, if a patient fails to keep an office visit, he or she will be charged a fee of $25 for a broken appointment. If there is a history of 2 or more broken appointments within the past few visits, our office reserves the right to review your account and decide if any subsequent appointments will be made.

An appointment is considered to be broken if any of the following occur:

- The patient fails to appear for the appointment.
- The patient appears more than 15 minutes late for a scheduled appointment.
- The patient cancels or reschedules with less than 48 business hours notice. *Exceptions include illness, weather, and other unpredictable events.

If an appointment needs to be cancelled or rescheduled for any reason, please notify our office at least 48 business hours in advance of the appointed time to avoid a broken appointment fee. Thank you for your cooperation.

______________________________ _______________

Patient / Guardian Signature Date

____

Patient / Guardian Print Name