Dr Heather Feray Bohan, DDS, PA
720 Lawrence St #200, Tomball, TX 77375
(281) 357-5002
www.drbohan.com

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature: Date:

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PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (???HIPAA???). 1. Tell your provider if you do not understand this authorization, and the provider will explain it to you. 2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider): 3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice. 4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. 5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (???CLIA???) prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense. 6. If this office initiated this authorization, you must receive a copy of the signed authorization. 7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as ???Psychotherapy Notes.??? All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client???s medical records to maintain a higher standard of protection. ???Psychotherapy Notes??? are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual???s medical records. Excluded from the ???Psychotherapy Notes??? definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release ???Psychotherapy Notes??? to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records. 8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual???s dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight

agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

DENTAL BENEFITS:

Firstly, we use the term "dental benefits" instead of "dental insurance" to accurately describe the type of healthcare plan involved. While many people commonly refer to their coverage as insurance, **it functions differently**. Insurance typically reimburses you for a loss, such as car insurance covering the value of your car if it's totaled. Similarly, health insurance covers hospital expenses resulting from an injury. With insurance, the insurer bears the risk. In contrast, a benefit plan is structured to cover specific costs. Your dental benefit plan may fully cover certain procedures and reimburse a percentage for others.

It's important to understand that your dental benefit policy constitutes a contract between you and your benefit administration company. Our office provides various services as a courtesy, including pre-treatment estimates sent to your benefit administrator upon request. However, it's not feasible for us to have exhaustive knowledge of every detail of your plan. It's your responsibility to communicate directly with your benefit administration company to understand the benefits provided by your employer.

Should you have any inquiries regarding pre-treatment estimates or service fees, it's advisable to address them before proceeding with treatment to minimize confusion. If any insurance claim remains unresolved by your carrier within 60 days, the outstanding balance automatically becomes "self-pay," and you'll receive a statement for the unpaid portion. Please note that some or all of the services rendered may not be covered by your dental benefit policy. Regardless of whether your dental benefit contributes, any remaining balance is your responsibility.

PAYMENT:

Please understand that regardless of any benefit coverage, you are ultimately accountable for the outstanding balance on your account. This includes all professional services provided, encompassing dental fees, surgical procedures, tests, office procedures, medications, and any other services not directly administered by the dentist.

- Payment in full is required at the time of service. If dental benefits are applicable, estimated patient co-payments and deductibles must also be settled at the time of service.
- A 3% Convenience Fee will be applied when a Credit/Debit card is used.
- Any unpaid balance exceeding 30 days will incur a monthly interest charge of 1.0% (APR 12%) or a late fee of $50. In the event of delinquent payment, the patient assumes responsibility for covering collection fees, attorney???s fees, and any court costs associated with recovering the outstanding balance on the account.
- Any refunds will be calculated after all claims have closed. Refunds are paid via check at the endo of the month.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation **48 hours** in advance, you will be charged **$75** for each one-hour appointment. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Dr Heather Feray Bohan, DDS, PA offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Dr Heather Feray Bohan, DDS, PA will use reasonable means to protect the security and confidentiality of email information sent and received. However, Dr Heather Feray Bohan, DDS, PA cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Dr Heather Feray Bohan, DDS, PA and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Dr Heather Feray Bohan, DDS, PA.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Dr Heather Feray Bohan, DDS, PA, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Dr Heather Feray Bohan, DDS, PA will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Dr Heather Feray Bohan, DDS, PA cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Dr Heather Feray Bohan, DDS, PA and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Dr Heather Feray Bohan, DDS, PA.

Patient's signature: Date: