Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care,

To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please call us. We will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient information (confidential)

Name_____ Birthdate _____ Home Phone _____

Address _____ City _____ Prov/State _____ Zip/P.C _____

Email _____ Cell Phone _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/ Prov _____ Full Time ☐ Part Time ☐

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ Prov/State _____ Zip/P.C _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate. _____ Financial Institution _____

Employer _____ Work Phone _____ SS#SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of employer _____ City _____ Prov/State _____ Zip/P.C _____

Insurance Company _____ Group# _____ Police/ID# _____

Ins.Co.Address _____ City _____ Prov/State _____ Zip/P.C _____

How much is your deductible? _____ How much have you used? _____ Max.Annual Benefits _____

_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ NO IF YES, COMPLETES THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS#/SIN _____ Date Employed_____

Name of Employer _____ Union or Local#. _____ Work Phone _____

Address of employer _____ City _____ Prov/State _____ Zip/P.C _____

Insurance Company _____ Group# _____ Police/ID# _____

Ins.Co.Address _____ City _____ Prov/State _____ Zip/P.C _____

How much is your deductible? _____ How much have you used? _____ Max.Annual Benifits _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5years If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication (s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra. Revati, Cialis or Levitra in the last 24 hours ?	☐	☐
7. Do you use tobacco ?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness Ousting more than 3 weeks)?	☐	☐
13. Women Only:		
a. An you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizure	☐	☐	Frequently tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsion	☐	☐	Cancer	☐	☐	Recent weight loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver disease	☐	☐
Diabetics	☐	☐	Joint replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	sexually transmitted Disease	☐	☐	Mitral Value Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Patient/Parent/Guardian _____ Date _____

Patient Name (Please Print) _____

EXPLANATION OF DENTAL INSURANCE AND DENTAL PLANS

Michael Furgason, D.D.S. Jason Fife, D.D.S. -1507 Coburg Road-Eugene, OR 97401-541-687-1442

We are pleased that you have dental insurance to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits, so with this in mind, please read the information regarding our policy on dental insurance benefits.

DO YOU ACCEPT MY INSURANCE? If your insurance plan allows you the freedom to choose your own dentist, then you can use your benefits in our office. We are happy to file your claim for you, and will accept assignments of benefits if your plan allows. Accepting assignment of benefits does not mean that we accept whatever the insurance company pays as full payment. Most insurance plans require you to pay a deductible and a portion of the bill.

HOW MUCH WILL THEY PAY? Once we have the opportunity to verify your dental insurance coverage and obtain an approximate breakdown of benefits, we are able to estimate your payment portion based on the information we receive, but **ONLY AN ESTIMATE**. Please understand that we do not have a contract with any insurance company (with the exception as a Premier provider for some insurances): therefore it is impossible to give you a guarantee of what the insurance company will pay at the time of service**. If we are unable to verify your insurance coverage, you are responsible for payment in full of all fees associated with your treatment at each visit.**

If you want to determine what your insurance will pay, we are happy to file a pre-treatment authorization with your insurance company prior to your treatment. This can take up to several weeks depending on the insurance company, but will give you the exact 'out-of-pocket' figure you require.

INSURANCE DIDN'T PAY WHAT NOW? Ultimately, you are responsible for all charges incurred in our office. We file your primary insurance claim as a courtesy to you. When payment is received we will go ahead and also file for the secondary insurance. Some procedures performed in our office may be covered by your medical insurance; we do not file this for you. We will provide you with an itemized statement of procedures performed. It is important that you recognize the insurance you have is a legal contract between YOU and YOUR insurance company. Our office is not and cannot be a part of that legal contract. If your insurance company does not pay a claim within 60 days, we reserve the right to request payment in full for services from you and let you collect the insurance due to you. Additionally, dental insurance is designed to defray the cost of your dental treatment. It is not intended as total payment for services and should not be used to determine the type or amount of treatment you receive.

I THOUGHT I PAID MY PORTION BUT I STILL OWE MORE, WHY? We base your estimated 'out-of-pocket' expense on the benefit verification information we receive from your insurance company, but there are many factors that can affect this estimate. There may be an annual deductible that must be met (individual or family), or you may have received treatment in another office. Further, insurance companies do not (and cannot in most cases) notify our practice of changes to your benefits, they only notify you. If any of these situations apply to you, please let us know as soon as possible.

WHAT IS UCR? UCR stand for Usual, Customary, and Reasonable. It is a term created by insurance companies to define what they are willing to pay for a particular procedure.

- I authorize my insurance company to pay the office of Dr. Michael Furgason and Dr. Jason Fife all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all claim submissions. I authorize the office of Dr. Furgason and Dr. Fife to release all information necessary to secure payment of insurance benefits. I understand that I am financially responsible for all fees regardless of whether or not they are covered by my insurance.I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment.

Patient/Parent/Guardian _____ Date _____

Patient Name (Please Print) _____

Financial Policy Acknowledgement

In the interest of excellent dental care, it is our desire to establish a financial policy to avoid any misunderstandings. Our primary goal is to provide our patients with high quality dental care with expertise, individual attention, and kindness.

Patient responsibility plays a big role in successful treatment. Attending scheduled visits, following and performing dental home care recommendations results in a winning smile for years to come.

- All accounts are due and payable at the time of your visit unless other arrangements have been made with our Office Manager.

- For patients with insurance, we will gladly bill your insurance for you as a courtesy, when you provide the necessary information. We will accept payment directly from the insurance company only for that percentage the company has estimated to cover. The insurance companies are very clear when they give any information regarding your coverage. They use a disclaimer that states *"all claims are subject to eligibility and plan provisions at the time the services are rendered. This is not a guarantee of coverage".* We do our best to contact your insurance company and get an insurance breakdown over the phone. With this information we are able to ***estimate*** your benefits and your portion. We encourage our patients to become familiar with their insurance benefits so as to ensure an understanding of the details of your benefits. We do require that you pay for the deductible and any non-covered fees at the time services are provided.

- We do our best to confirm our patients by phone as well as postcards. We understand that situations occur that may hinder you from keeping your appointment. However, we do require 48 hours notice for any cancellation. Failure to provide 48 hour notice for cancellation may result in a minimum $35 cancellation fee. We strive to provide superior dental care at affordable cost by being efficient. When we are given prior notice of a cancellation we can reschedule your appointment and let another patient have the appointment time that was originally scheduled for you. Thank you for your cooperation in advance. Having understanding patients enables us to better serve the needs of all our patients.

I have read the financial policy and understand that payment is due at the time services are rendered. I also understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I give J. Michael Furgason, DDS permission to bill my insurance to collect any benefits due for charges incurred by me or my policy benefactors.

Patient/Parent/Guardian _____ Date _____

Patient Name (Please Print) _____

Dr. Michael Furgason, D.D.S.

Dr Jason Fife, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the designated privacy officer for our office at

541-687-1442
1507 Coburg Road
Eugene, OR 97401

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your physician. This notice is intended to inform you of how we protect, use and disclose your information, as well as to explain your right to control these disclosures.

Your Health Information

We may use and disclose health information about you without your permission for the following purposes:

1. We may disclose your information for treatment purposes and to coordinate your medical care.
2. We may disclose your information to ensure that you receive insurance benefits.
3. We may disclose your information internally to enhance the operation of our practice. This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information to comply with a limited number of legal requirements, as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested.

Effective Date: March 23, 2013

Our Duties

We are required by law to keep your information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change the terms of our Notice of Privacy Practices and to make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights

Please note that your are entitled to very specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact in order to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain limited circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

Right to Amend

If you believe our records contain errors, you may make a written request that they be amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information, unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions

You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the **Request for Restriction on Use/Disclosure of**

Medical Information to our designated Privacy Officer/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Officer/

Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Officer/Contact.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/ Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list (for example, on paper or electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Complaints and Investigations

We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint you may have regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information.

You may also contact our on-site Privacy Officer/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information

We may disclose your information for the following purposes without your consent:

For Treatment Purposes

We may disclose information needed for the provision, coordination or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions

to your pharmacy, scheduling lab work and ordering X-rays. Family members and other health- care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management and collections activities. We may also be required to disclose your information to your insurer for review of the medical necessity, coverage, appropriateness or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. You have the right to restrict disclosures of your PHI to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing or credentialing activities
- Arranging for or conducting medical review, legal services or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Appointment Reminders

We may contact you (via voicemail messages, postcards or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

2. **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

3. **Research.** We may use and disclose health information about you for research projects that are subject to a special approval

process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

4. **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

5. **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

6. **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

7. **Public Health Risks.** We may disclose health information about you for public health reason in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

8. **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

9. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

10. **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

11. **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

12. **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

13. **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

14. **Deceased Person's PHI** may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any Consent we may have obtained from you.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time.

If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*. However, we cannot take back any uses or disclosures already made with your permission.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Michael Furgason, D.D.S.
Jason Fife, D.D.S.
1507 Coburg Road
Eugene, OR 97401
541-687-1442

You will not be penalized for filing a complaint.

J. MICHAEL FURGASON, D.D.S
B. JASON FIFE, D.D.S. 1507 COBURG ROAD
EUGENE, OREGON 97401
541-687-1442

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient/Parent/Guardian _____ Date _____

Patient Name (Please Print) _____

J. Michael Furgason, D.D.S.
B. Jason Fife, D.D.S 1507 Coburg Road
Eugene, Oregon 97401
541-687-1442

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

Authorized persons whom we may discuss your Protected Health Information with:

_____

_____

You may contact me and or leave information with:

My home phone _____

My mobile phone _____

My email _____

Other _____

Patient/Parent/Guardian _____ Date _____

Patient Name (Please Print) _____