DR. RONALD W. RISTOW
825 SOUTH MAIN STREET OCONTO FALLS WI 54154 920-846-3163

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 ACTIVITES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF THE ABOVE MENTIONED.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

THIS NOTICE HAS BEEN POSTED AND YOU MAY REQUEST A COPY OF IT.

RIGHT TO REVOKE: YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE HAD TAKEN IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION AND THAT WE MAY DECLINE TO TREAT YOU OR CONTINUE TREATING YOU.

YOUR SIGNATURE_____

DATE_____, 20____

I AUTHORIZE RELEASE OF ANY AND ALL INFORMATION TO THE FOLLOWING REPRESENTATIVES:

_____**RELATIONSHIP**_____

RONALD WILLIAM RISTOW, D.D.S., L.L.C.
825 South Main Street
Oconto Falls, Wisconsin 54154
(920)846-3163

Financial Policy

I. General Financial Policy:

A. It is our policy to collect charges as services are rendered.
B. This office recognizes the person that brings in a minor child as the responsible party. We will not bill a second party.
C. A 24 hour notice (minimum) is expected if an appointment is unable to be kept OR a charge will be Applied.

II. Insurances - Our contract is with the patient, not the Insurance Company.
You are responsible for your bill. As a courtesy, our office will file your insurance.

A. Patients must show that the deductible has been met.
B. This office will extend credit for the insurance portion of the bill. ESTIMATED COINSURANCE IS DUE AT TIME OF SERVICE.
C. Dr. Ristow's concern is with the patient's oral health. There may be instances when the insurance maximum will run out, or there may be an insurance Non-Payment. We will do what we can to assist you in collecting from your insurance company. We will not be held responsible, as all insurances pay differently. **It is YOUR responsibility to know your benefits.**
D. 50% of all major work is expected the day treatment begins. If there is no insurance, the other half is due on the last day of treatment. (Major dental treatments usually require more than one visit.)

III. Expectations –
C. Workers Compensation – You must report an injury to your employer and bring in a worker's compensation form with the employer's signature, address and phone number.
D. Auto Accident – You must complete and auto accident report and provide the name and address of the Attorney and/or the insurance agent. If a questionable responsibility of payment exists, direct payment will be expected the day of service. Your Attorney or insurance company will reimburse you.

IV. Billing –
E. Billing is sent out the first week of each month.

V. Collection – This is a last resort measure taken that is occasionally necessary
To receive payment from outstanding accounts.
F. This action is taken when accounts that reach 90 days with no payment made.
G. Charges for collection and/or court charges will be added to the patient's balance.
H. Once you are turned over to collection, you will have to contact the Collection Agency to make any future payment arrangements.
I. If you request to be seen again in our office, you will be responsible for payment at the time that services are rendered.

ASK ABOUT OUR IN OFFICE CARE CREDIT FINANCING

SIGNATURE_____DATE_____

Patient Information

Patient Name_____ Date of Birth_____

Mailing Address_____ City_____ State____ Zip_____

Home Phone_____ Work Phone_____ Other_____

Email_____

Would you like to receive text messaging from our office (please circle) Yes / No

Marital Status_____

Physican Name_____ Phone_____ Last Exam_____

Preferred Pharmacy_____ Phone_____

Person Financially Responsible_____

Dental Insurance_____ Group Number_____ ID Number_____

Medical History

Sex_____

Do you PREMEDICATE WITH AN ANTIBIOTIC for dental appointments due to any of the following? (please circle) Heart Surgery Joint replacement Other_____

Do you or have you ever taken medication for BONE LOSS OR OSTEOPOROSIS? YES NO
What medication did you take?_____

Please circle:

Y N	Are you pregnant?	Y N	Colitis
Y N	Are you nursing?	Y N	HIV/ AIDS/ other STD
Y N	Do you take birth control?	Y N	Cosmetic Surgery
Y N	Do you smoke or use tobacco/vape?	Y N	Diabetes
Y N	Abnormal Bleeding	Y N	Breathing Problems
Y N	Do you take blood thinners?_____	Y N	Drug Abuse
Y N	Alcohol Consumption? Per week_____	Y N	Emphysema
Y N	Seasonal allergies	Y N	Epilepsy
Y N	Anemia	Y N	Fainting
Y N	Angina Pectoris	Y N	Cold or Canker Sores
Y N	Arthritis	Y N	Headaches
Y N	Artificial joint	Y N	Glaucoma
Y N	Heart valve replacement	Y N	Jaundice
Y N	Asthma	Y N	Stents

CONTINUED ON OTHER SIDE→→

Y N	Blood Transfusion? Date_____
Y N	Cancer
Y N	Chemotherapy/Radiation/other cancer treatment
Y N	High Blood Pressure
Y N	Low Blood Pressure
Y N	Kidney Problems
Y N	Liver Disease
Y N	Mitral Valve Prolapse
Y N	Pace Maker
Y N	Pneumonia/Lung Problem
Y N	Psychiatric Problems
Y N	Radiation Therapy
Y N	Rheumatic Fever
Y N	Seizures
Y N	Shingles
Y N	Sickle Cell Disease
Y N	Sinus Problems or Surgery
Y N	Stroke
Y N	Thyroid Problems
Y N	Tuberculosis
Y N	Ulcers
Y N	Heart Attack
Y N	Heart Surgery
Y N	Heart Defect
Y N	Hemophilia
Y N	Hepatitis/type_____

PLEASE LIST ANY AND ALL ALLERGIES:

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PLEASE LIST ALL MEDICATIONS YOU TAKE INCLUDING VITAMINS/SUPPLEMENTS:

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Is there any other condition that is not listed above? Describe

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Recent Surgeries?_____

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SIGNATURE_____**DATE**_____

NOTES: