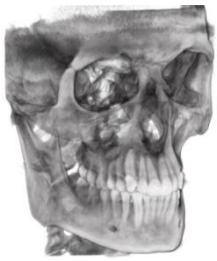

3D ADVANTAGE

A Mobile Cone Beam Imaging Company

Please Call For An Appointment:
(949) 282-0083
Fax: (949) 382-1442

ATTENTION PATIENTS

1. California law requires that this slip be present at time of appointment.
2. PAYMENT IS REQUIRED AT TIME OF APPOINTMENT UNLESS DOCTOR TAKES RESPONSIBILITY ON THIS FORM.
3. 3D Advantage does NOT accept assignment of insurance. Reimbursement paperwork for Insurance will be supplied upon request. Contact your carrier for coverage information.
4. Please inform us during scheduling if wheelchair ramp is needed. (Check here) ☐
5. 24-HOUR CANCELLATION IS APPRECIATED.

Doctor's Office Only

PLEASE PRINT CLEARLY IN ALL FIELDS

Patient Name:_____

Practice Name:_____

Referring Doctor:_____

Office Address:_____

City:_____ Zip Code:_____

Phone Number:_____

Payment Responsibility: ☐Doctor ☐Patient (Fee $_____)Email:_____

Format Options (please check)

- ☐ Images printed
- ☐ Images burned to CD (pdf)
- ☐ Images burned to CD (DICOM)
- ☐ Viewer Software
- ☐ Images Emailed

NewTom Cone Beam CT Scan

☐ Implant Survey
- Maxillary Arch
  - ☐ Tooth #_____
  - ☐ Entire Arch
- Mandibular Arch
  - ☐ Tooth #_____
  - ☐ Entire Arch

☐ Impacted Teeth
- Tooth #_____

☐ TMJ Survey
- ☐ Closed Only (Transaxial Included)
- ☐ Open/Closed
- ☐ Splint in

☐ Pathology
- Tooth #_____
- Please indicate pathological conditions
- ☐ Sleep Apnea
- ☐ Sinus Study
- ☐ Orthodontic Scan (DICOM)

RIGHT								LEFT							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

☐ Radiologist Report (Additional Fee) **Recommended**

3rd Party Companies
- ☐ Simplant
- ☐ Glidewell
- ☐ Nobel Guide
- ☐ Other
- ☐ Stent In
- ☐ Scan Stent

Authorized Signature _____

Special Instructions:_____

Patient Only

PLEASE PRINT CLEARLY

Patient Name: _____ Date of Birth: _____ Age:_____ Male/Female

Home Address: _____ City:_____ State:_____ Zipcode: _____

Phone Number: _____ Work/Cell Number: _____

Parent/Gaurdian (If patient is under 18): _____

Do you have a Contagious Illness? Yes_____No_____ Female Patients- Are you Pregnant? Yes_____ No_____

****I have read and understand HIPAA on the reverse side of this referral****

Signature: _____ Date: _____

Format Options with Additional Charges- Ask Tech

☐ Additional CD's- Qty_____ $_____ ☐ Additional Prints- Qty_____ $_____ ☐ Overnight Mail $_____

Tech Only

Van: ☐ #1 ☐ #2 ☐ #3 Technician: _____

Procedure: _____ Next Appointment Date with Dr:_____

Scan Charge: $ _____ Additional Charges: $ _____ Total: $ _____ Type: _____

Delivered: Print:_____ CD:_____ Email:_____

HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

3D Advantage, LLC will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that 3D Advantage, LLC may use or disclose the cone-beam scan and/or report for the purpose(s) of diagnosis and treatment by the referring physician.

By signing this authorization you agree that 3D Advantage, LLC or its Business Associates may disclose your personal health care information to the patients referring physician or any future physician at the discretion of the patient.

Further, by signing this authorization you acknowledge that you will receive, at your request, a copy of and have read and understand 3D Advantage, LLC's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While 3D Advantage, LLC has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from 3D Advantage, LLC at its office or by sending a written request by email to mobile3dadvantage@yahoo.com.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by 3D Advantage, LLC for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that 3D Advantage, LLC has taken action in reliance on it. A revocation is effective upon receipt by 3D Advantage, LLC, of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of 3D Advantage, LLC, or (d) six years from the date this authorization was executed.

By signing the reverse side of this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

3D Advantage will provide the patient with a copy of this signed authorization upon request.