TGS ENDODONTICS

Richard S. Shapiro, D.D.S.

www.tgsendo.com

The Medical Quarters
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404-256-4772 Phone

REQUEST FOR LIMITATIONS & RESTRICTIONS OF PROTECTED HEALTH INFORMATION (PHI)
(HEALTH PLAN RESTRICTION FOR ITEMS/SERVICES PAID IN FULL)

PATIENT PLEASE NOTE: **IF TGS ENDODONTICS HAS NOT BEEN PAID IN FULL FOR ITEM/SERVICES WHEN I MAKE THIS REQUEST, THEN I UNDERSTAND IT MAY DENY THIS REQUEST FOR LIMITATION & RESTRICTION. YOUR REQUEST NEEDS TO BE LEGIBLE, PRECISE AND COMPLETE OR IT MAY BE DENIED.**

Patient Name : _____ (Please print)

Date Of Birth : _____

Patient Address : _____
Street

_____
Apartment #

_____
City, State Zip

I am asking **TGS Endodontics** (a/k/a/ Tissura, Gregory & Shapiro, P.C.) not to give information about the following item(s) and/or service(s), for which this dental practice has been paid in full, to the health plan indicated below, for purposes of payment or health care operations, unless required by law:

Item(s) or Service(s): _____

Health Plan: _____

*I understand that **TGS Endodontics must agree** to this requested restriction if the practice has received payment in full for these item(s) or services(s).*

Patient Signature : _____ Date: _____

Dental Practice: Has payment in full been received by dental practice? ◯ Yes ◯ No

Dentist or Administrator's Signature: Date:

_____ _____

For Dental Office Use Only

☐ Agree to (TGS Endodontics has been paid in full.)

☐ Not Agree to (TGS Endodontics can only disagree if dental practice has not received payment in full)

Signature: _____ Date: _____

(Office Staff)

Print Form

(TGS Revised 2/7/2014)