

ENDODONTIC SPECIALISTS, INC.

First Insurance Center
1100 Ward Ave., #1015
Honolulu, Hawaii 96814
(808) 532-3900

Gary Yonemoto, DDS
Wade Nobuhara, DDS

Mary Savio Medical Plaza
98-1247 Kaahumanu St., #218
Aiea, Hawaii 96701
(808) 483-4111

INSURANCE AUTHORIZATION-SIGNATURE ON FILE

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

DATE

SIGNATURE

Form #55

Endodontic Specialists, Inc.

**Acknowledgement of Receipt of
Notice of Privacy Practices**

**** You may refuse to sign this acknowledgement ****

I, _____

(Please print name) _____
(Date)

For Office Use

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify): _____
