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**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)