HIPAA Notice of Privacy Practices

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may not be able to grant your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

• You can ask us not to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request, and we may say "no" if it would affect your care.
• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that

information for the purpose of payment or our operations with your health insurer.
• We will say "yes" unless a law requires us to share that information

Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information at the top of the page
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
• Include your information in a hospital directory
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to
lessen a serious and imminent threat to health or safety

In these cases we never share your information unless you give us written permission:

• Marketing purposes
• Sale of your information
• Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

• We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition

Run our organization

• We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

• We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
• We can share health information about you for certain situations such as:
• Preventing disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety

Do research

• We can use or share your information for health research.

Comply with the law

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

• We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests

• We can use or share health information about you:
• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date_____

I hereby acknowledge that I have received a copy of this offices Notice of Privacy Practices. I may refuse to sign this acknowledgement. To obtain a paper copy I may request it from the office or the website.

First Name_____ Last Name_____

Signature_____ Date_____

PATIENT INFORMATION

Date _____

Name _____ MI _____ Last Name _____

Preferred Name _____ Gender _____ DOB _____

SSN _____ Cell _____ Home _____

Adress _____

City _____ State _____ Zip Code _____

Email _____ How did you learn of our office? _____

For your convenience our office can communicate with you by text or email. It's okay for the office to

Text me ☐ Email me ☐ Send me appointments reminders ☐

Patient Is (Select All That Apply)

Patient ☐ Policy Holder ☐ Responsible party ☐

In case of emergency, please contact

Full name _____ Phone Number _____ Relationship _____

Who is responsible for your account? _____

Insurance Information

Do you have Insurance?

Yes ☐ No ☐

Insurance Company Name _____ I.D. # _____

Address _____ City _____

State _____ Zip Code _____ Group # _____

Group Name _____

Signature _____ Date _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under the care of a physician? Yes ☐ No ☐

Please explain _____

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐

Please explain _____

Have you ever had a serious head or neck injury? Yes ☐ No ☐

Please explain _____

Are you taking any medications, pills or drugs? Yes ☐ No ☐

Please explain _____

Do you take, or have you taken, Phen-Fen or Redux? Yes ☐ No ☐

Please explain _____

Do you or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes ☐ No ☐

Please explain _____

Are you on a special diet? Yes ☐ No ☐

Please explain _____

Do you use tobacco? Yes ☐ No ☐

Do you use controlled substances? Yes ☐ No ☐

Please explain _____

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment? Yes ☐ No ☐

Women: Are you? Pregnant ☐ Nursing ☐ Taking oral contraceptives ☐

Are you allergic to any of the following?

Aspirin	☐	Penicillin	☐	Codeine	☐	Acrylic	☐	Metal	☐
Latex	☐	Sulfa Drogs	☐	Local anestetic	☐	Other	_____		

Do you have or have you had any of the following diseases or medical conditions?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments	☐ Alzhei-mer's Disease
☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss	☐ Anaphy-laxis	☐ Drug Addiction
☐ Hepatitis B or C	☐ Renal Dialysis	☐ Anemia	☐ Easily Winded	☐ Herpes
☐ Rheumatic Fever	☐ Angina	☐ Emphy-sema	☐ High Blood Pressure	☐ Rheu-matism
☐ Arthritis Gout	☐ Epilepsy or Seizures	☐ High Choleste-rol	☐ Scarlet Fever	☐ Artificial Heart Valve
☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles	☐ Artificial Joint	☐ Excessive Thirst
☐ Hypo-glycemia	☐ Sickle Cell Disease	☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat
☐ Sinus Trouble	☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Trans-fusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach / Intestinal Disease	☐ Breathing Problem
☐ Frequent Headaches	☐ Liver Disease	☐ Stroke	☐ Bruise Easily	☐ Genital Herpes
☐ Low Blood Pressure	☐ Swelling of Limbs	☐ Cancer	☐ Glaucoma	☐ Lung Disease
☐ Thyroid Disease	☐ Chemo-therapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteop-orosis	☐ Tuber-culosis	☐ Cold Sores/Fever Blisters
☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths	☐ Congenital Heart Disorder	☐ Venereal Disease
☐ Parathy-roid Disease	☐ Ulcers	☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care
☐ Yellow Jaundice				

Have you ever had any serious illness not listed above? _____

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

I consent to the diagnostic procedures and treatment by the dentist(s) of this office necessary for proper dental care.

Signature_____ Date_____

DENTAL INFORMATION

Reason for today's visit

Please explain _____

Are you in pain Yes ☐ No ☐

Please explain _____

Please indicate any of the following problems by selecting the corresponding box:

☐ Discomfort, clicking, or popping in jaw	☐ Lost / broken filling(s)	☐ Stained teeth	☐ Difficulty closing jaw	☐ Red, swollen, or bleeding gums
☐ Teeth grinding / clenching	☐ Locking jaw	☐ Difficulty opening jaw	☐ A removable dental appliance	☐ Ringing in ears
☐ Bad breath	☐ Loose / shifting teeth	☐ Blisters / sores in or around the mouth	☐ Broken / chipped tooth	☐ Burning tongue / lips
☐ Gum Disease	☐ Prolonged bleeding from an injury / extraction	☐ Toothache	☐ Swelling / lumps in mouth	☐ Recent infections or sore throat
☐ Food caught between teeth	☐ Other	☐	☐	☐

If other, please explain _____

My teeth are sensitive to:

Hot ☐ Cold ☐ Sweets ☐ Biting ☐

FINANCIAL POLICIES

As validated by my signature on the bottom of this form, I understand and agree that:
All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.

If there is dental insurance on the account, I understand that the clinic has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total.

Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

The clinic will make every effort to accommodate my scheduling needs.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

First Name_____ Last Name_____

Signature_____ Date_____

OFFICE POLICIES

Our goal is to provide high quality care to our patients and respect their schedule as well. In fairness to other patients, and the office staff, we require advanced notice when changing or cancelling an appointment.

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you give us 48 hours notice. We understand that conflicts arise; however missing your appointment or canceling without 48 hours notice will result in a charge of $50.

Patients who continue to no-show and/or cancel without notice may be dismissed from the practice and asked to find another dentist.

Any patient who is late by 15 minutes or more will be considered a "no show" for their appointment and will need to reschedule and be charged $50.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise the patient at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

I have read, understand and agree to the above appointment policy.

First Name_____ Last Name_____

Signature_____ Date_____