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(800) 243-4675

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NOTICE OF PRIVACY PRACTICES

Effective Date: ______________________________

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer
Telephone: (______) ______–____________
Fax: (______) ______–____________
Email:
Address:

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

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Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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<u>OFFICE POLICY:</u> Please read and initial where indicated to acknowledge that you understand and agree to our office policy. A copy of this office policy will also be provided to you for your record.

Welcome to our practice. In our continuing efforts to provide comprehensive dental care to you, our valued patients, we ask that you become acquainted with our office policies. If at any time you have any questions, please feel free to ask so that we may better serve you. All recommended treatments are in the best interest to our patients. We will ***NOT*** allow insurance companies to dictate treatment, and so we will inform you of the fees before we perform all procedures. We will assist you in your payment options to help you receive the treatment that is necessary for your needs. Please note that no two mouths are alike; therefore, we will customize treatment to suit your individual needs.

Payment Policy

Payment or co-payments for your visits are due at the time services are completed, unless other payment arrangements have been approved in advance. For your convenience, we accept cash, personal checks, debit cards, and major credit cards. In addition, as a courtesy, we also offer a revolving line of credit through a third party, CareCredit (upon approval). This line of credit allows you to start treatment today and spread payments over a comfortable period of time.

Initial: ________

Dental Insurance

If you have insurance, we will help you determine the coverage you have available. We accept assignment of insurance benefits as a courtesy to our patients, provided that you submit a completed original insurance claim or card. Please keep in mind that your dental insurance is a contract between you and the insurance company, not between your dentist and the insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. If for any reason your insurance company fails to pay for services rendered, you are responsible for all payments. As a courtesy to you, we will be happy to file your claim and handle insurance questions from our office on your behalf.

Initial: ________

Appointments & Cancellation Policy

We reserved appointment time especially for you and your specific dental needs. When you cancel on short notice, other patients that needed treatment cannot be seen and the time and money we pay to our staff and for overhead is wasted. Therefore, we ask for your consideration and that you kindly give us a 48-hour notice if you are unable to keep your appointments. For Oral Surgery, Periodontal Procedures, Implants, Crowns & Bridge Appointments, these "bigger" appointments require larger spans of time set-aside especially for you. We do ask for a 72-hour notice if you are unable to keep these “bigger” appointments. We may charge a minimum of sixty dollars ($60.00) per hour should there not be adequate notice.

Initial: ________

Finance Option

With our convenient payment plan administered by CareCredit, you can have the smile of your dreams today. CareCredit enables you to finance 100% of your dental care with NO money down, NO interest, no upfront costs, no annual fees, and no pre-payment penalties. CareCredit works just like a revolving credit card so it is easy to use and you do not have to reapply after each treatment. Approval is fast and easy. To learn more about CareCredit, call 1-800-677-0718 or visit their website at http://www.carecredit.com.

Other Fees when Applicable

From time to time, we receive a request for duplicating dental records. Please note that there is some cost incurred, therefore we may require a processing fee and at least 5 business days to process such request. In the event that your check is returned, there will be a twenty-five dollar ($25.00) returned check fee applied to your account. Payment must then be paid within 48 hours of notice from the bank in cash or money order. In addition, in the event that your balance becomes sixty (60) days past due and there is no contact with our office regarding payment, your account may be turned over to an attorney or collection agency. You will be charge an extra processing fee as well as any collection agency/attorney fees.

Initial: ________

Signature: ____ Date:________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Patient Information (Confidential)

Name____ Date__________________
First Middle Last

Address ______________________ City ______________________ State________ Zip_______

Cell #__________________ Soc. security #______________ Birth date______________ Home phone______________

Email ____

Check Appropriate Box ☐ Minor ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

If college student, F.T./P.T., name of school______________________ City______________ State______

Patient's or parent's employer______________________________ Work phone________________

Business address ______________________ City__________________ State______________ Zip_______

Spouse or parent's name ________________ Employer________________ Work phone________________

Whom may we thank for referring you ____

Person to contact in case of an emergency ______________________________ Phone__________________

Responsible Party (Only if Patient is a Minor)

Name of person responsible for this account ____________________________ Relationship to patient______________

Address ____ Home Phone__________________

Driver's license #______________________ Birth date______________ Soc. security #__________________

Employer____ Work phone__________________

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured ____ Relationship to patient______________

Birth date______________________ Soc. security #__________________ Date employed______________

Name of employer__________________ Union or local #__________________ Work phone______________

Employer address ______________________ City__________________ State__________ Zip_______

Insurance co.______________________ Tel. #______________ Grp. #__________ Policy/I.D. #__________

Ins. co. address______________________ City__________________ State__________ Zip_______

How much is your deductible ________________ How much have you used__________ Max annual benefit____________

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured ____ Relationship to patient______________

Birth date______________________ Soc. security #__________________ Date employed______________

Name of employer__________________ Union or local #__________________ Work phone______________

Employer address ______________________ City__________________ State__________ Zip_______

Insurance co.______________________ Tel. #______________ Grp. #__________ Policy/I.D. #__________

Ins. co. address______________________ City__________________ State__________ Zip_______

How much is your deductible ________________ How much have you used__________ Max annual benefit____________

X______________________________________ ______________________

Signature of patient or parent if minor **Date**

Patient Medical History

Patient's Name ______________________ **Date of Birth** ______________

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 that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health ______	☐	☐
2. Have there been any changes in your general health within the past year ______	☐	☐
3. Date of your last physical exam ______		
4. Physician's name ______		
Address ______		
Phone no. ______		
5. Are you now under the care of a physician ______	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness ______	☐	☐
Please explain ______		
7. Are you taking any medicine(s), including non-prescription medicine? ______	☐	☐
If yes, what medicine(s) are you taking ______		

	YES	NO
8. Have you had any abnormal bleeding ______	☐	☐
9. Do you bruise easily ______	☐	☐
10. Have you ever required a blood transfusion ______	☐	☐
11. Have you had a recent weight loss ______	☐	☐
12. Have you ever taken Fen-Phen or Redux ______	☐	☐
13. Do you use tobacco ______	☐	☐
14. Do you or have you used controlled substances ______	☐	☐
15. Are you wearing contact lenses ______	☐	☐
16. Do you have any disease, condition, or problem not listed above that you think I should know about ______	☐	☐
Women only:		
Are you pregnant or think you may be pregnant ______	☐	☐
Are you nursing ______	☐	☐
Are you taking birth control pills ______	☐	☐

	YES	NO
Are you allergic to or have you had reactions to:		
Local anesthetics like novocaine ______	☐	☐
Penicillin or other antibiotics ______	☐	☐
Sulfa drugs ______	☐	☐
Barbiturates, sedatives, or sleeping pills ______	☐	☐
Aspirin ______	☐	☐
Iodine ______	☐	☐
Any metals (e.g., nickel, mercury, etc.) ______	☐	☐
Latex/rubber ______	☐	☐
Other (please list) ______		
Do you have, or have you ever had, any of the following:		
Rheumatic heart disease or rheumatic fever ______	☐	☐
Scarlet fever ______	☐	☐
Heart defect or heart murmur ______	☐	☐
Heart trouble, heart attack, or angina ______	☐	☐
Chest pain ______	☐	☐
Shortness of breath ______	☐	☐
Pacemaker ______	☐	☐
Heart surgery ______	☐	☐
High/low blood pressure ______	☐	☐
Congenital heart problem ______	☐	☐
Swelling of feet, ankles, hands ______	☐	☐
Hepatitis, jaundice, or liver disease ______	☐	☐
Stroke ______	☐	☐
Sinus trouble ______	☐	☐
Lung or breathing problems ______	☐	☐
Asthma or hay fever ______	☐	☐
Hives or skin rash ______	☐	☐

	YES	NO
Fainting or dizzy spells ______	☐	☐
Diabetes ______	☐	☐
AIDS or HIV infection ______	☐	☐
Thyroid problem ______	☐	☐
Allergies ______	☐	☐
Arthritis or rheumatism ______	☐	☐
Joint replacement or implant ______	☐	☐
Stomach ulcer ______	☐	☐
Kidney trouble ______	☐	☐
Tuberculosis ______	☐	☐
Persistent cough ______	☐	☐
Cough that produces blood ______	☐	☐
Chemotherapy (cancer, leukemia) ______	☐	☐
Sexually transmitted disease ______	☐	☐
Epilepsy or seizures ______	☐	☐
Anemia ______	☐	☐
Glaucoma ______	☐	☐
Nervousness ______	☐	☐
Tonsillitis ______	☐	☐
Tumors ______	☐	☐
Mental health care ______	☐	☐
Back problems ______	☐	☐
Chemical dependency ______	☐	☐
Mitral valve prolapse ______	☐	☐
Cortisone treatment ______	☐	☐
Cold sores/fever blisters ______	☐	☐
Hypoglycemia ______	☐	☐
Eating disorders ______	☐	☐

Patient Medical History

Patient's Name ______________________ **Date of Birth**______________

Reason for this visit______________________
When was your last dental visit______________ What was done then______________
How often did you visit the dentist before then ______________
Previous dentist (name and location) ______________
Have you had a complete series of dental exams (x-rays) taken? When and where ______________
How often do you brush your teeth ______________How often do you floss your teeth______________
Is your drinking water fluoridated ______________

	YES	NO
Do your gums bleed while brushing or flossing	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do you feel pain to any of your teeth	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck, or jaw injuries	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐
Do you bite your lips or cheeks frequently	☐	☐

	YES	NO
Have you noticed any loosening of your teeth	☐	☐
Does food tend to become caught between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Ever worn a bite plate or other appliance	☐	☐
Have you ever had any difficult extractions in the past	☐	☐
Have you ever had any prolonged bleeding following extractions	☐	☐
Do you wear dentures or partials	☐	☐
If yes, date of placement ______________		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	☐	☐
Have you had ortho/braces in the past	☐	☐
Would you be interested in teeth whitening	☐	☐
Have you had an unfavorable dental experience	☐	☐

If you could change anything about your smile, what would you change? ______________
____
____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X______________________Date______________

Signature of patient or parent if minor

Doctor's Comments______________________
____
______________________**Signature**______________________**Date**______________