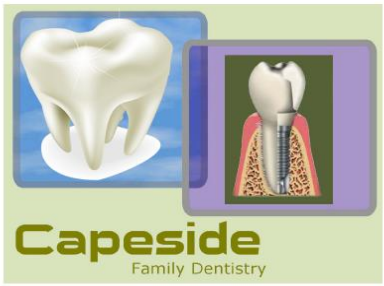

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Dental Practice Policy

Dear Patient:
Please Read and sign at the bottom

- Welcome to our dental office. We appreciate the opportunity to assist with your dental needs and concerns. Our goal is to provide you with the best dental care available in an efficient and professional manner. Together we can accomplish this goal. Like any business we have office policies that we must adhere to so that we can operate in a manner that will benefit our relationship. We will define those policies in the next couple of paragraphs.

- We provide several payment options to fit your financial needs. We offer the convenience of credit card payments using Visa or MasterCard. We also provide low or no interest third party financial payment plans. **However, check will not be accepted on your first visit.** _____(initial)

- We must have 48-hour notice should you be unable to come to your appointment. We will make every effort to confirm your appointment with you. However it is your responsibility to keep up with your appointment time. **Failure to give us a 48-hour notice will result in a $40.00 broken appointment charge billed to your account**. We have reserved this time for you and must know if you will be unable to keep it. _____(intitial)

- All co-pays and deductible portions are due at prior to treatment. As a courtesy, we will be happy to file your insurance. **Please understand that all treatments are not contingent or dependent on payment by your insurance company. Fees quoted are an estimate based on information from your insurance carrier, not a guarantee of payment. In the event we do not receive payment from your insurance provider within 45 days of billing, the amount owing will be billed to you and payment expected within 15 days after billing.** We will be happy to provide you with a copy of the claim we submitted to your insurance carrier. _____(initial)

- It is the responsibility of the patient/guarantor to provide this office with any future changes in insurance plans, address and phone number prior to treatment, and to make certain that we are listed as your in-network provider.

- Our office accepts faxed eligibility. However faxed eligibility is not a guarantee of coverage. **It is your responsibility to verify your eligibility.** Should your insurance company deny the claim for any reason, **we will bill you our normal fees and all charges become your responsibility to pay.** _____ (initial)

- **Any accounts over 60 days will incur a 1.5% per month finance charge base on the unpaid balance. These charges will accrue each month there is an outstanding balance.** _____ (initial)

- **I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 33% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, and all other expenses so stated elsewhere. The authorized fee of 33% and the additional costs and charges listed above represent the actual costs incurred by our office to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signers failure to pay as specified in this agreement.** _____ (initial)

- **Return checks, stop payments and credit card charge back incur a fee of $25.00 or 5% of the face amount, whichever is greater, and an amount equal to the charges incurred by our bank.** _____ (initial)

- We try very hard to adhere to a schedule. If you are more than 15 minutes late, we may have to reschedule your appointment. Sometimes an emergency will occur that will make us run behind, please be patient with us as it could be you with that emergency. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing us and look forward to a long term relationship with you and your family.

_____(Patient/Guardian Signature if under 18) _____ (Date)

PATIENT'S NAME_____Birthdate_____ Sex__ Marital Status_____

SSN_____Driver's License No._____E-Mail_____

Residence Address_____City_____State____Zip_____

How long at present address?_____ Phone:H_____W_____Cell_____

Employer_____Occupation_____

Address_____How long at present employer_____

Physician's Name_____Address_____Ph._____

GUARDIAN(if under 18) _____ Birthdate_____ Sex__ Marital Status_____

SSN_____Driver's License No._____E-Mail_____

Residence Address_____City_____State____Zip_____

How long at present address?_____ Phone:H_____W_____ Cell_____

Employer_____Occupation_____

Address_____How long at present employer_____

Do you have insurance?_____If not, how do you intend to pay? ____Cash ____Check____Credit Card

SUBSCRIBER_____ Birthdate_____ Sex__ Marital Status_____

SSN_____Driver's License Number_____

Residence Address_____City_____State____Zip_____

Employer_____Occupation_____

Address_____Phone_____

Insurance Company Name and address_____

_____

Plan Name/Group Number_____Ins. Ph._____Relation to Patient_____

Secondary Insurance_____

Person Financially responsible for this account_____

Nearest relative not residing with you_____

Relationship to you _____Phone_____

Who may we thank for referring you?_____

Address_____Phone_____

In case of an emergency please contact_____Phone_____

SIGNATURE_____

Patient Name:_____

MEDICAL HISTORY – Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE:

	YES	NO
1. Asthma, hay fever sinusitis, or other allergies		
2. Allergy to penicillin, aspirin, local or general anesthetic, or other drugs; specify:		
3. Blood pressure or heart problems		
4. Rheumatic fever or heart murmur		
5. A pacemaker or open heart surgery		
6. Diabetes, liver, kidney, thyroid, or lung problems		
7. Ulcers or stomach problems		
8. Hepatitis or Jaundice		
9. Epilepsy or nervous disorders		
10. Bleeding or clotting disorders		
11. Arthritis		
12. Venereal Disease, Herpes		
13. Acquired Immune Deficiency Syndrome (AIDS)		
14. Any other illness		
15. Do any wounds heal slowly or persent complications?		
16. Are you presently taking any medicine? Specify:		
17. Are you presently under the care of a physician?		
18. When was your last physical exam?		
19. Have you ever been hospitalized? Date: Reason:		
20. Have you had X-ray treatments or chemotherapy?		
21. Are you presently on a diet?		
22. Women ( ) Are you taking birth control pills? ( ) Are you pregnant?		
23. Do you smoke? How long? How many packs per day?		
24. Do you have osteoporosis? If Yes, what medication are you taking?		

PATIENT SIGNATURE_____ DATE _____

DENTIST SIGNATURE_____ DATE _____

Please complete reverse side

DENTAL HISTORY

Patient Name:_____

DATE OF LAST DENTAL EXAM _____

DATE OF LAST FULL MOUTH X-RAY_____WHERE TAKEN_____

	YES	NO
1. Have you had trouble from previous dental care?		
2. Do you have pain in your jaw or near your ears?		
3. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4. Have you experienced any growths or sore spots in your mouth?		
5. Does any part of your mouth hurt when clenched?		
6. Have you ever had Novocaine or other local anesthetic?		
7. Have you ever had Nitrous Oxide (laughing gas)?		
8. Have you ever had general anesthesia?		
9. Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics?		
10. Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Do you have a bad taste in your mouth or mouth odor?		
14. Have you ever had instructions on the care of your gums?		
15. Have you ever been diagnosed with or treated with gum disease?		
16. Do you chew on only one sid of your mouth? If so, why?		
17. Do you habitually clench or grind your teeth during the night or day?		
18. Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?		

Is there any other problem not covered above that you would like to discuss?_____

_____

PATIENT SIGNATURE_____DATE_____

DENTIST SIGNATURE_____ DATE _____

Please complete reverse side

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Page 1 of 2)

1. **Client's name**: _____
   First Name Middle Name Last Name

2. **Date of Birth**: ____/____/____ 3. **SSN**: ____-____-____ 4. **Date authorization initiated**: ____/____/____

5. **Authorization initiated by**: _____
   Name (client or provider) (If provider, please specify relationship to client)

6. **Information to be Used or Disclosed**:

   ☐ My dental information relating to the following treatment or condition: _____

   ☐ Most recent ____ years of record

   ☐ My dental records for the following date(s): _____

   ☐ Entire dental record

      ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse

      ☐ Include ☐ Exclude: My health information related to HIV/AIDS

   ☐ Other information to be used or disclose (describe information in detail): _____

   _____

   _____

7. **Purpose of Use or Disclosure**:

   ☐ Treatment, Payment or Health Care Operations

   ☐ Disclosure to Life Insurer for Coverage Purposes

   ☐ Disclosure to Employer of results of pre-employment physical or lab tests

   ☐ Marketing Purposes

   ☐ To the Following Family Members: _____

   ☐ Other (describe each purpose of the requested use and disclosure in detail): _____

   _____

   _____

8. **Person(s) Authorized to Make the Disclosure**: _____

9. **Person(s) Authorized to Receive the Disclosure**: _____

10. **This Authorization will: ☐ not expire, ☐ expire on ____/____/____ ☐ or upon the happening of the following event**: _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of the Client: _____

Signature of Personal Representative: _____

Relationship to Client if Personal Representative: _____

Date of signature: ____/____/____

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS
(Page 2 of 2)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

   _____

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.