To: Patients &/or Legal Guardians,

1). Legal Guardians **MUST** bring Official Court Documents Showing Legal Guardianship of Minor Patients.

2). You **MUST** fill out and sign **ALL** paperwork **PRIOR** to coming in for your appointment and bring all paperwork with you the day of your appointment!

3). You **MUST** bring with you, a Valid Driver's License or a Valid Picture ID and your Current Insurance Card/Information!

4). You **MUST** bring all Current X-rays from previous dentist **OR** all new x-rays will be taken the day of your appointment at the patient's expense!

Current X-rays Include:
1). Full Mouth X-rays (within 3 years)
2). Panoramic X-ray (within 3 years)
3). Bitewings (within 1 year)

5). For Biohazard & Safety Reasons :
Only 1 Adult may join a patient in treatment areas! All Children MUST remain in Waiting Room with a RESPONSIBLE ADULT! (Our Staff is unable to watch children!) **Patients without a Responsible Adult to watch children in Waiting Room, will not be seen!**

6). If you are unable to keep your scheduled appointment, you **MUST** call and cancel at least 24 hours in advance to avoid a "Patient No Showed/Cancelled without Sufficient Notice" Fee for **EACH** patient that has a scheduled appointment! *Exception: If proof is provided of an emergency or extenuating circumstance!*

Failure to complete the above may result in appointment rescheduling or denial of services!

Yours in Dental Health,
Barth Family Dentistry

Barth Family Dentistry, PSC
1821 Florence Pike #2, Burlington, KY 41005
Phone: 859-689-7700 Fax: 859-689-9641

Coronavirus (COVID-19) Screening

Patient Full Name (Print): _____ Patient DOB: _____

Patient Full Address: _____ Patient Phone#: _____

1). Are you experiencing any of the following? Circle all that apply: Fever (100.4 F or higher), Cough,

Headaches, Body Aches, Nausea, Vomiting, Difficulty Breathy

2). Have you traveled outside the United States within the last 30 days? Yes No
If Yes, Where? _____

_____

3). Have you been exposed to COVID-19 or been in the same room with anyone who has or has been exposed to COVID-19 within in the last 30 days? Yes No
If Yes: Date of Exposure: _____

How Exposure Occurred: _____

Name, Address, & Phone Number... of the person who exposed you to the COVID-19: _____

_____

_____

(Print) Parent/Guardian Name: _____

Signature of Patient/Parent/ Guardian: _____

Witness: _____ Date: _____

Today's Screening Temperature taken by Dental Staff: _____ Staff Initial: _____

(Patient's Information)

BARTH FAMILY DENTISTRY, PSC, MEDICAL HISTORY FORM Updated 10-10-19

Last: _____ First: _____ Middle: _____

Date of Birth: _____ Height _____ Weight: _____ Primary Language: _____

Pharmacy & Location: _____ Pharmacy Phone#: _____

Medical Physician's Name, Phone #, & Address: _____

Cadiologist's Name, Phone#, & Address: _____

OBGYN's Name, Phone#, & Address: _____

*** Please mark any conditions PAST or PRESENT that apply to you! Answers are completely confidential.**

__*Previous Endocarditis* Date: _____

__*Artificial Heart Valve* Type: _____ Date: _____

__*Artificial Joint Replacement* Type: _____ Date: _____

Complications: _____

__*Congenital Heart Defect* Type: _____

__AV Shunt/Patent Ductus Arteriosus

__Transplant *Type:* _____ Date: _____

__Any Heart Valve Damage *Type* _____ Date: _____

__Mitral Valve Prolapse, *Complications?* _____

__Pacemaker/Difibrilator or Cardiac Stint

__Angina pectoris/Chest pain

__High Blood Pressure

__Irregular Heart Beat *Type:* _____

__Heart disease or Heart Attack *Dates:* _____

__Congestive Hearth Failure

__COPD (Chronic Obstructive Pulmonary Disease)

__Tendency to Bleed/On Blood Thinner

__Hemophilia

__Anemia

__Sickle Cell Disease/ Trait

__Hearing Impaired

__Glaucoma or Cataract

__Tobacco: *Packs per Day?* _____

__Alcohol: *Drinks per Week?* _____

__Stroke (Major or Minor) *Difficulties:* _____

__Vape Cigarettes: *# per Day?* _____

__Has a Living Will *(Please give copy to receptionist)*

__Drug Addiction (Any Type)...*Type:* _____

__Victim of Violence,Rape,Abuse (Type &*Dates):* _____

__Currently Pregnant: *Weeks Pregnant:* _____ *Due Date:* _____

__Currently Nursing/ Breast Feeding

__Currently Taking Birth Control Pills *Type:* _____

__PreClampsia, Eclampsia Dates: _____

__Disability of Any Kind *Type:* _____

__Diabetes Type 1 or 2

__Thyroid Disease

__Taken Prednisone/Steroids...*Type/Dates:* _____

__Nervousness/Anxiety

__Psychiatric (or) Behavioral: Type: _____ *Dr:* _____

__Sinus Issues

__Epilepsy, seizures

__Emphysema

__Tuberculosis (TB) *Circle: Active or Non-Active*

__Asthma

__Kidney/ Bladder conditions

__Dialysis *Where:* _____ *Dates:* _____

__HIV-Positive/AIDS...*Counts: CD4* _____ *Viral Load* _____

__Sexually Trans. Disease *Type:* _____

__Tumor or Cancer. *Type:* _____

__Chemotherapy *Where:* _____ *When:* _____

__Radiation Therapy *Date:* _____ *Entry/Exit Point:* _____

__Hepatitis/ Yellow Jaundice...*Type:* _____

__Cirrhosis of Liver

__Anorexia or Bulimia

__Acid Reflux or GERD

__Work with blood products or needles?

__Conditions not listed here *(Use back as needed):* _____

__I want & willing to accept HELP/Counseling for Domestic Violence/ Rape/ Abuse of any kind.

ARE YOU ALLERGIC TO:

__Latex (rubber)

__Local Anesthetics, Type: _____

__Penicillin

__Aspirin

__Codeine

__Food, Wine, Animal, Preservatives such as Sulfite (*not Sulfa*)

List any other drug allergies: _____

****List Medications and Surgeries on the Back of this form!**

DENTAL HISTORY:

__I have a dental check up twice a year?

__My teeth feel loose or hurt when biting?

__My gums bleed when brushing?

__I have pain or popping of jaw joint?

__Have you ever worn braces or false teeth? Dates: _____

__Drinks more than 2 soft drinks a day?

How many times a **WEEK** do you? Brush _____ Floss _____

To the best of my knowledge, all information above is correct & true. If anything changes, I will inform the dentist at the beginning of all visits.

Print Parent/Legal Guardian Full Name: _____ **Signature:** _____

Witness: _____ **Date:** _____

Surgeries

Date:_____ Type of Surgery: _____
Hospital: _____ Dr. & Phone #: _____

Date:_____ Type of Surgery: _____
Hospital: _____ Dr. & Phone #: _____

Date:_____ Type of Surgery: _____
Hospital: _____ Dr. & Phone #: _____

Date:_____ Type of Surgery: _____
Hospital: _____ Dr. & Phone #: _____

Date:_____ Type of Surgery: _____
Hospital: _____ Dr. & Phone #: _____

Date:_____ Type of Surgery: _____
Hospital: _____ Dr. & Phone #: _____

Date:_____ Type of Surgery: _____
Hospital: _____ Dr. & Phone #: _____

Medications: (Include Vitamins, Supplements and Over-the-counter medications:

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

Medication Name/ Dose/Times taken a day: _____

BARTH FAMILY DENTISTRY, PSC - Registration & Insurance

PATIENT INFORMATION

Date _____

Last Name _____ First Name _____ Middle Initial _____ Social Security # _____ Driver's License # _____

Home Phone #: _____ Cell/Text #: _____ Email: _____

Full Home Address _____ City _____ State _____ Zip Code _____

Sex: __M __F Age: _____ Date of Birth: _____ Marital Status: _____

School Status of Patient: (Please Check): Full Time Student: _____ Part-Time Student: _____ Not Applicable: _____

Patient Employed By: _____ Occupational Position: _____

Full Business Address: _____ Business Phone # _____

Who Referred You/ How did you hear about us ? _____

In Case of Emergency Notify: _____ Relationship _____ Phone # _____

****

PRIMARY INSURANCE: (Give card to receptionist to copy):

Person Holding the Insurance Policy: _____ SS# _____

Policy Holder's Full Home Address: _____

Policy Holder Employed By: _____ Occupation: _____

Full Business Address: _____ Business Phone # _____

Date of Birth _____ Relationship to Patient: _____ Phone# _____

Insurance Company & Address: _____ Phone # _____

Contract # _____ Group # _____ Subscriber # _____

SECONDARY INSURANCE: (Give card to receptionist to copy):

Person Holding the Insurance Policy: _____ SS# _____

Policy Holder's Full Home Address: _____

Policy Holder Employed By: _____ Occupation: _____

Full Business Address : _____ Business Phone # _____

Date of Birth _____ Relationship to Patient: _____ Phone# _____

Insurance Company & Address: _____ Phone # _____

Contract # _____ Group # _____ Subscriber # _____

****

SIGNATURE ON FILE:

1). I authorize use of this form on all my insurance submissions
2). I authorize release of information to all my insurance carriers
3). I understand that I am ultimately responsible for my bill.
4). I authorize payment directly to BARTH FAMILY DENTISTRY, PSC
5). I permit a copy of this authorization to be used in place of the original.

By my signature below, I certify that I have read, understand, accept and agree with as well as agree to adhere to all of the above mentioned policies & understand all of my responsibilities set forth as stated above.

Print Patient Full Name: _____ **Signature:** _____

Print Parent/Legal Guardian Full Name: _____ **Signature:** _____

Witness: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF
BARTH FAMILY DENTISTRY'S NOTICE OF PRIVACY PRACTICES

Dr. Charity A. Barth Omosivwe NPI:198-270-4656

You may refuse to sign this acknowledgement. However refusal to sign will not change the policies of this office.
This form merely states that this office has either given you a copy of our notice of privacy practices or at least has given you the opportunity to receive a copy of this office's notice of privacy practices.

I, the patient or legal guardian, have received a copy or have been given the opportunity to receive a copy of BARTH FAMILY DENTISTRY, PSC's Notice of Privacy Practices. I am also aware that any amendments will be posted in the Privacy Policy Folder located in the lobby of Barth Family Dentistry, which is my responsibility to read and make myself aware of any amendments or updates.

I understand that when legally, medically, dentally, and/or financially necessary to treat and/or conduct business, that all personal information which includes but is not limited to; financial, insurance, medical, dental, and/or personal issues that are related to my care will be shared with:

1). **Head of Household, the person(s) who hold the insurance coverage on the patient and/or the person(s) responsible for paying the bill.**
2). **A third-party responsible for paying the bill**
3). **Your listed emergency contact.**
4). **Your insurance company**
5). **Consulting Doctors**
6). **Law Enforcement as warranted.**
7). **Collection Agency, Attorney, Court System as warranted.**

Please list below any additional person(s) that we MAY discuss your personal information with:

Full Name: _____ Relationship to Patient: _____ Phone #: _____

Full Name: _____ Relationship to Patient: _____ Phone #: _____

Full Name: _____ Relationship to Patient: _____ Phone #: _____

By my signature below, I certify that I have read, understand, accept and give consent to the above statements.

Print Patient Full Name: _____ **Signature:** _____

Print Parent/Legal Guardian Full Name: _____ **Signature:** _____

Witness: _____ **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*
____ *Communication barriers prohibited obtaining the acknowledgement*
____ *An emergency situation prevented us form obtaining acknowledgement*
____ *Other (Please Specify)*

Comments : _____

Employee's Signature: _____ ***Date:*** _____

BILLING/FINANCIAL & OFFICE POLICIES for Barth Family Dentistry, PSC

TREATMENT: The type of treatment you receive from Barth Family Dentistry, PSC is based upon our professional dental judgment, and NOT on whether the procedure is covered by your dental insurance benefit plan!!!!

DENTAL INSURANCE: Our office is happy to file claims with your dental insurance carrier. However, since the **terms of your coverage is contract** between **YOU & YOUR INSURANCE CARRIER,** questions, problems, or disputes about your insurance coverage need to be addressed directly to your insurance company. For all non-dental insurance claims, patients must pay in full upfront and will be reimbursed by their non-dental insurance, such as but not limited to Medical, Worker's Compensation, Legal Suits, etc. It is the patient's responsibility to confirm with your dental insurance company that Barth Family Dentistry/Dr. Charity A. Barth-Omosivwe is an "in-network" or "out-of-network" provider prior to being seen and the patient is responsible for all charges not covered by their insurance policy.

It is YOUR (the patient's) responsibility to know what your insurance coverage and limitations regardless if your insurance coverage is "In or Out of network", which includes examinations, x-rays and treatment of any kind. Payment of your co-pay, deductible, estimated amount not covered by your dental insurance is due at the time services are rendered. Any amount not covered by your insurance or denial of coverage for any reason by your insurance coverage, or patient refusal to return to this office within 30 days to complete a procedure previously started, such as (but not limited to) laboratory procedures, becomes the patient's responsibility and payment is due immediately with no grace period. Barth Family Dentistry reserves the right to ask for and expect payment in full with no grace period at any time, even prior to submitting dental claims to the patient's dental insurance.

Disputes With your Insurance Company: If you have a dispute with your insurance company (Dental or other) over coverage, that dispute must be resolved between you and your insurance company. The amount owed to Barth Family Dentistry during the duration of your dispute is your responsibility and payment is due immediately in full, with no grace period.

Dental Pre-Authorizations: Pre-Authorizations for treatment are submitted in writing **upon patient request.** Pre-authorizations must be sent with up-to-date diagnostic X-rays, along with all necessary insurance, personal, dental, and/or medical information. If you don't wait for your pre-authorization response before beginning treatment, you are still responsible for any amount not covered by your insurance for any examinations, x-rays and/or treatment. We recommend that you get your pre-authorization response back prior to starting treatment.

Laboratory Cases: The day a laboratory procedure begins (such as but not limited to Dentures, Partials, Crowns, etc.), your estimated portion is due in full. If insurance denies/covers less than the estimated portion, you will be billed the remaining costs which is due immediately with no grace period.

Change of Personal Information: It is your responsibility to notify us, in writing, of any changes in your address, phone number, employment information, school status, insurance coverage and etc. so that you may maximize your insurance benefit. Monthly statements are mailed out as a courtesy.

Family Balance: **All balances must be paid in full in order to proceed with future treatment.** An 18% (eighteen percent) annual rate service charge will be applied with the minimum amount of $20.00 every month on all late balances. This $20 late fee is applied to all late payments and/or payments short of full balance due, of which there is no grace period, at 30, 60, 90 and 120 days past due. Guarantors (the patient or guardians) are responsible for any and all (but not limited to) collection agency recovery fees, attorney fees and/or legal fees, court costs, interest on delinquent accounts, as well as the time the doctor and/or staff spends working on (but not limited to) filing paperwork, appear for court, mediation/proceedings/and/or legal meetings and/or frivolous legal charges. The time, the doctor and/or staff spend on the above issues are $500.00 an hour. These fees must be paid in full prior to returning to this practice for future treatment. There is a $60.00 charge on all returned checks (per check) and an $80.00 charge to file with the county attorney, per check. At 120 days past due your account may be turned over to our collection agency, court and/or attorney. All of the above stated responsibilities of the patient are due immediately without a grace period. If Barth Family Dentistry is notified as being included in any bankruptcy files, that patient and immediate family members will be dismissed as patients of Barth Family Dentistry for failure to meet patient financial obligations to Barth Family Dentistry.

Financing: Barth Family Dentistry does not offer in house payment plans.

Missed or Late for Appointments: **If you must cancel an appointment, please notify us 24 hours in advance.** There will be a charge equal to the amount of a periodic exam for any missed appointments or canceling less than 24 hours before of your appointment time, unless written proof of an emergency is provided. If missed or late for appointments becomes a habit, Barth Family Dentistry, reserves the right to dismiss you as a patient of the practice. Patients more than 15 minutes late for scheduled appointments may be asked to reschedule and may be charged a "No Show" Fee. "Reminder Calls" for your scheduled appointment is strictly a courtesy. It is your (the patient's) responsibility to keep & to be on time for scheduled appointments.

Medicaid Patients: By law, "No Show" fees will not apply to Medicaid patients but after 3 "No Show" appointments or late arrivals for appointments, we reserve the right to dismiss you from Barth Family Dentistry as a patient. We ask that you arrive 30 minutes prior to your scheduled appointment to fill out/update paperwork. Arrival less than 15 minute prior to your scheduled appointments deemed as late for your appointment and you may be asked to reschedule. Any procedure not covered by Medicaid must be paid in full prior to the start of that procedure.

Nitrous Oxide/Oxygen: Nitrous Oxide is usually not covered by insurance. It is the guarantor's responsibility to pay for nitrous regardless if nitrous oxide is deemed necessary by the doctor or if requested by the patient to ease anxiety during dental procedures.

Copies of Dental Records: Kentucky State law mandates that the patient or designated representative is entitled to 1 (one) free copy of his/her dental records at no charge. Each additional copy of chart records are $25.00 each copy and $10.00 for certified mailing.

Additional Patient Forms: There is a $25 fee to fill out Family Medical Leave, Disability, Legal Documents and etc. Paperwork.

By my signature below, I certify that I have read, understand, accept and agree with as well as agree to adhere to all of the above mentioned policies & understand all of my responsibilities set forth as stated above.

Print Patient Full Name: _____ **Signature:** _____

Print Parent/Legal Guardian Full Name: _____ **Signature:** _____

Witness: _____ **Date:** _____

Updated October 10, 2019

Barth Family Dentistry Authorization/Release for Exam, Performance of Procedures:

I, the patient/parent/guardian of the patient, hereby freely and willingly consent to the performance as well as agree to pay all dental fees that insurance does not cover. for a comprehensive examination/emergency examimations, all necessary X-rays which may include, a full mouth series, periapicals, bitewings, panoramic x-rays, digital pictures, prophylatic cleaning/gross debridement and fluoride treatment for minors on my initial, emergency and all subsequent recall visits. I consent to any procedure deemed necessary according to the diagnosis on any examination, and/or any dental treatment/procedures which may later become apparent during treatment. I give consent to correct oral deficiency, abnormality, and/or infection. I consent to the administration of anesthetic agents and/or nitrous oxide as needed for my dental treatment. I acknowledge that no guarantee or assurance is made as to the results that may be obtained from treatment. I understand that a diagnosis and/or treatment may be refused to me if I refuse to consent to an emergency/comprehensive examination and/or any/all of the above stated x-rays. I understand that I reserve the right to ask any questions pertaining to my treatment. I understand that I have the right to deny any/all treatment even if it is against the advice of the doctor regardless if the advise/treatment plan is presented to me orally or in writing. I understand that I am solely responsible for paying for all diagnostic costs not covered by insurance at the time services are rendered with no grace period. **If you are concerned about diagnostic costs, please ask for diagnostic fees in writing PRIOR to being seen.**

Emergency patients that have only had a limited examination, a limited treatment plan and limited treatment preformed are considered NOT to be "A Patient of Barth Family Dentistry". Only after a comprehensive examination is completed and a COMPREHENSIVE treatment plan is printed out and signed by the patient/guardian, is the patient "A Patient of Barth Family Dentistry".

For the purpose of diagnostic examination and to formulate the most appropriate treatment plan for each individual, I consent to photographs, models, closed-circuit television, preparation of drawings and similar illustrative graphic material to be taken of me and used in consultation with fellow dental colleagues. I further consent that **Barth Family Dentistry, PSC** may dispose of any tissue or parts of the oral cavity which it may be necessary to remove.

I, the patient and/or legal guardian, give Barth Family Dentistry, PSC, consent to X-rays and Digital Pictures for diagnostic purposes. I also give my permission to use these digital pictures and x-rays taken of myself, (before, during and after dental treatment) to display in the dental waiting room, dental office, website, internet, email, video, television, fax, etc., to be used as "before and after" and educational tools, and/or consultations with other patients, doctors or the public at large to view, at no fee, and/or liability to Barth Family Dentistry, PSC / Dr. Charity A. Barth. I understand that if I disapprove of my image being displayed in public via digital photography and/or X-rays that I must submit a written, dated and signed letter to Barth Family Dentistry specifically stating that "I do not give my consent to display digital photography and/or x-ray for public view". I understand that if I refuse Diagnostic Digital Pictures or X-rays deemed necessary by the doctor for diagnostic purposes that Barth Family Dentistry has the right to refuse the examination and/or treatment.

I understand and consent that I may be tested for the Human Immunodeficiency Virus (HIV) and Hepatitis B, C or any other blood-bourne diseases in the event of an occupational blood exposure to a healthcare worker. Results will be made available to the Dentist and the employee to whom was exposed. By law, this information is confidential and the above listed people are prohibited to disclose information to anyone else.

I understand that appointments cannot be made after office hours and that I or the person for whom I am consenting, will be expected to be available for treatment during the hours that Barth Family Dentistry, PSC is open.

I authorize Barth Family Dentistry, PSC to release any information, dental records, images and x-rays concerning my treatment as may be necessary to process insurance claims, payments for care/treatment provided as well as to Medical/Dental Specialists that Barth Family Dentistry PSC consults with or refers to. Otherwise a "Consent to Release Records" form must be signed before it will be released.

I understand that for Biohazard & Safety Reasons: Only 1 Adult may join a patient in treatment areas! All Children MUST remain in Waiting Room with a responsible adult! (Our Staff is unable to watch children!) **Patients without a Responsible Adult to watch children in Waiting Room, will not be seen!**

I also understand that any patient 17 years old and younger must have parent or legal guardian present during any and all dental examinations and dental procedures. I also understand that any patient 17 years and younger must have parent or legal guardian approve and sign treatment plan prior to dental procedures.

By my signature below, I certify that I have read, understand, accept and give consent to the above statements.

Print Patient Full Name: _____ **Signature:** _____

Print Parent/Legal Guardian Full Name: _____ **Signature:** _____

Witness: _____ **Date:** _____

Barth Family Dentistry
1821 Florence Pike #2, Burlington, KY 41005

Dr. Charity A. Barth
Office: 859-689-7700

Opioid Analgesics (REMS9Risk Evaluation & Mitigation Strategy) Patient Counseling Guide:
What you need to know about Opioid Medicines for Risk of Prescription Drug Tolerance, Dependence & Addition.

Please keep this guide with your medications so you can better understand what you need to know about your opioid plan medicine. Go over this information with your healthcare provider. Then, ask your healthcare provider about anything you don't understand.

What are Opioids? Opioids are strong prescription medicines that are used to manage severe pain and anxiety. They include: Heroin, Dilaudid (hydromorphone), Demerol (Meperidine), Methodone, Duragesic (fentanyl), Codeine, MS Contin (morphine), Percocet, Percodan, Oxycontin, Tylox, Roxicet (oxycodone), Vicodin, Lorcet, Lortab (hydrocodone).

What Are the Serious Risks of Using Opioids?

- Opioids have serious risks of addiction and overdose. Too much opioid medicine in your body can cause your breathing to STOP, which could lead to death. This risk is greater for people taking other medications that make you feel sleepy or people with sleep apnea.
- **Addiction:** is when you crave drugs (like opioid pain medicines) because they make you feel good in some way. You keep taking the drug even though you know it is not a good idea and bad things are happening to you. Addiction is a brain disease that may require ongoing treatment. Addiction occurs when the person is drug dependent but also displays a psychological effect that includes: compulsive behavior to get the drug, craving for the drug, and continued use of the drug despite negative consequences, like legal problems, or losing a job.
- **Risk Factors for Opioid Abuse:** You have a history of addition or a family history of addiction. You take medicines to treat mental health problems. You are under the age of 65 (although anyone can abuse opioid medicines).
- **You can get addicted to opioids even though you take them exactly as prescribed, especially if taken for a long time.**
- If you take an opioid medicine for more that a few days, your body becomes physically drug dependent. This is normal and it means your body has gotten used to the medicine thus higher doses are need for the same effect. Withdrawal symptoms will occur when a substance suddenly is stopped. You must taper off the opioid medicine (slowly take less medicines) when you no longer need it to avoid withdrawal symptoms.
- **Signs/Symptoms of Opioid Withdrawal:** Anxiety, Irritability, Craving the drug, rapid breathing, yawning, runny nose, salivation, gooseflesh, nasal stuffiness, muscle aches, vomiting, abdominal cramping, diarrhea, sweating, confusion, enlarged pupils, tremors, loss of appetite.

How Can I Take Opioid Pain Medicine Safely?

- Tell your doctor about all the medicines you are taking including vitamins, herbal supplements & over-the-counter medicines.
- Read the Medication Guide that comes with your prescription
- Take your opioid medicine exactly as prescribed.
- Do Not cut, break, chew, crush, or dissolve your medicine. If you can't swallow your medicine whole, talk to your doctor.
- When your healthcare provider gives you the prescription, ask: How long should I take it? What should I do if I need to taper off the opioid medicine (slowly take less medicine)?
- Call you healthcare provider if the opioid medicine is not controlling your pain. Do not increase the dose on your own.
- Do not share or give your opioid medicine to anyone else. Your healthcare provider selected this opioid and the dose just for you. A dose that is okay for you could cause an overdose or death for someone else. Also, it is against the law.
- Store your opioid medicine in a safe place where it cannot be reached by children or stolen by family or visitors to you home. Many teenagers like to experiment with pain medicines. Use a lock box to keep your opioid medicine safe. Keep track of the amount of medicine you have.
- Do not operate heavy machinery until you know how your opioid medicine affects you. Your opioid medicine can make you sleepy, dizzy, or lightheaded.

What Should I Avoid Taking While I am Taking Opioids?

Unless prescribed by your healthcare provider, you should avoid taking alcohol or any of the following medicines with an opioid because it may cause you to STOP breathing, which can lead to death:

- Alcohol: Do Not drink any kind of alcohol while you are taking opioid medicines.
- Benzodiazepines (like Valium, Xanax, Ativan, Klonopin)
- Muscle Relaxants (like Soma or Flexeril)
- Sleep Medicines (like Ambien or Lunesta)
- Other Prescription Opioid Medicines

Barth Family Dentistry
1821 Florence Pike #2, Burlington, KY 41005

Dr. Charity A. Barth
Office: 859-689-7700

What other options are there to help with my pain?

- Opioids are not the only thing that can help you control your pain. Ask your healthcare provider if your pain might be helped with a non-opioid medication, physical therapy, exercise, rest, acupuncture, types of behavioral therapy or patient self-help techniques.
- Signs/Symptoms of Opioid Abuse: Analgesia (feeling no pain), Sedation, Euphoria (feeling high), Respiratory depression (shallow/low breathing), small pupils, nausea, vomiting, itchy or flush skin, constipation, slurred speech, confusion or poor judgment.

What is Naloxone?

- Naloxone is a medicine that treats opioid overdoses. It is sprayed inside your nose or injected into your body.
- Use Naloxone if you have it and call 911 or go to the emergency room right away if you or someone else has taken an opioid medicine or you think they might have taken it.
- Give Naloxone to a person, even a child who has not taken an opioid medicine will not hurt them.
- Naloxone is never a substitute for emergency medical care. Always call 911 or go to the emergency room if you've used or given naloxone.

Where can I get Naloxone?

- There are some naloxone products that are designed for people to use in their home.
- Naloxone is available in pharmacies. Ask your healthcare provider about how you can get naloxone. In some states, you may not need a prescription.
- When you get your naloxone from the pharmacy, read the patient information on how to use the naloxone and ask the pharmacist if anything is unclear.
- Tell your family about your naloxone & keep it in a place where you and your family can get to it in an emergency.

When you no longer need your opioid medicine:

- Dispose of it as quickly as possible. The Food and Drug Administration recommends at most opioid medicines be promptly flushed down the toilet when longer needed, unless a drug take-back option is immediately available. A list of the opioid medicines that can be flushed down the toilet is found here: https://www.fda.gov/drugdisposal.

What If I Have More Questions?

- Read the Medication Guide that comes with your opioid medicine prescription for more specific information about your medicine.
- Talk to your healthcare provider or pharmacist and ask them any questions you may have.
- Visit: www.fds.gov/opioids for more information about opioid medicines

---

If, I or those whom I am legally responsible, are prescribed any of the above medications, I understand that I or those whom I am legally responsible for, may develop a tolerance, physical dependence, and may even become addicted to that medication. Since the chances of becoming addicted are greatly reduced by following the doctor's exact instructions while taking this medication, I will only take these medications as they are strictly prescribed by the doctor and will notify the doctor immediately should any signs/symptoms or other side effects not listed above arise while taking this medication. I am fully aware of all risks, benefits, alternatives and consequences of taking this medication and I accept full responsibility for my personal actions and/or drug reactions while on this medication. And all my questions on this matter has been answered to my full satisfaction.
By my signature, I have read, understand and agree to the above statement:

Print Full Name: _____

Signature: _____ Date: _____

Witness: _____

Updated: October 08-2019

Patient's Copy to Keep for Your Records!

BARTH FAMILY DENTISTRY'S NOTICE OF PRIVACY PRACTICES
This notice describes how your personal/protected health information (PHI) may be used and/or disclosed and how you can get access to this information.
PLEASE REVIEW IT CAREFULLY

OUR LEGAL DUTY

Barth Family Dentistry, PSC,(BFD) is committed to providing the best possible health care. Each time you visit BFD, a record of your visit is made. This record is placed in a chart which thus becomes your **personal/protected health information (PHI)**. It contains your personal information, name, address, diagnosis, date of birth, date of death, telephone numbers, fax numbers, electronic email addresses, social security number, medical record number, dental record number, account number, health plan beneficiary number, license number, vehicle identifiers, serial numbers, (any other unique identifying number, characteristics, or codes), health information, insurance information, signs and symptoms of health/dental problems, examinations and test results, x-rays, digital intra-oral and extra-oral pictures/ photographs, treatment given and plans for future treatment. Some of the information found in your chart is also entered into our clinic management computer system.

Federal and State laws require us to keep **ALL** of your health information private. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your right concerning your PHI. We **MUST** follow the privacy practices that are described in the Notice. This Notice takes effect **APRIL 14, 2003**, and will remain in effect until we replace it.

We have the right to change privacy practices and terms of this Notice at any time, provided such changes are permitted by law. We keep the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you as well as posted in the office waiting room.

You may ask for a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES ANS DISCLOSURES OF HEALTH INFORMATION

PAYMENT: We will use and disclose your PHI to receive payment for services provided to you. Any Business Associate we use that helps us in collecting payment from you must keep your information confidential. Your PHI may be sent to responsible financial party or business associates such as **A.** Business Associates functions could include claims processing, transcription, administration, data analysis, utilization review, quality assurance, billing, benefit management, practice management, re-pricing, legal, actuarial, accounting, consulting or data aggregation, billing offices, insurances carriers, collection agencies, small claims court, head of household, insurance policy holder, third-party payer, and government payment programs. (ex: Medicare, Medicaid, Passport).

TREATMENT: We may use or disclose your PHI to a healthcare provider treating you to provide treatment to you, receive payment for treatment and treatment options. Disclosures may be made, but not limited to:

A. Health care providers such as consulting doctors/dentists, medical doctors, jail or prison doctors/personnel, hospitals, specialists, emergency contact, health care proxy and specialists that may not be connected to Barth Family Dentistry, PSC (such as pathologists, radiologists, laboratories).

B. We may also use and disclose your PHI about you to remind you that you have an appointment with us for treatment or that it is time for you to schedule a regular checkup with us, or to give you information about treatment choices. This information may be communicated to you by leaving a message on your answering machine, or by sending you a letter or post card.

HEALTHCARE OPERATIONS: We may use and disclose your PHI to help us improve the care and services we offer. Healthcare operations include quality assessment and improvement activities, review of the competence and qualifications of healthcare professionals, evaluation of practitioner/provider performance, and conducting training, accreditation, certification, licensing, and credentialing activities and education of employees.

YOUR AUTHORIZATION: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us such an authorization, you may cancel it in writing at any time. A cancellation of you authorization will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice.

PERSONS INVOLVED IN CARE, INCLUDING FAMILY AND FRIENDS: Unless you do not want us to (and thus must be submitted to us in writing), we may disclose your PHI to family members, other relatives, close personal friends or any other person (either in person, phone, or ansering machine/voice mail) that may be helping you with your care and/or payment for your care. The head of the household (the person who carries the insurance on the family), will be made aware of all financial (thus procedures) related to anyone in the head of household, for all insurance and charges are applied to the head of household in order for insurance claims to be accepted by the insurance. If you do not want the head of household to be made aware of your charges or procedures then you must pay upfront and in full and then you must file your own insurance claim, as well as notify us in writing of your wishes. We may use or disclose your PHI to notify, or assist in the notification of (including or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition or death, Doctors and other medical personnel, will use their best opinion in deciding when to release your PHI to another person. We will also use our professional judgment and our experience with common practices on when to allow a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information for you.

MARKETING HEALTH-RELATED SERVICES: We will not use your PHI for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your PHI when we are required to do so by law such as but not limited to: Identity Theft, Abuse, Theft by Deception, and Insurance Fraud.

ABUSE OR NEGLECT: We may disclose you PHI to appropriate authorities if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose you PHI to the extent necessary to avoid a serious threat to your health or safety or the to health or safety of others.

NATIONAL SECURITY: We may disclose your PHI of Armed Forces personnel to military authorities under certain circumstances. We may disclose you PHI to authorize federal officials when required for lawful intelligence, counterintelligence, and other national security activities. We may disclose PHI of inmates or patients to correctional institutions or law enforcement officials having lawful custody, under certain circumstances.

Patient's Copy to Keep for Your Records!

PATIENT RIGHTS

ACCESS: you have the right to look at or get copies of you PHI, with limited exceptions:

A. Psychotherapy

B. Information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

You must make a request in writing to gain access to you PHI. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request by sending us a letter to the address at eh end of this Notice. Once we have your written request, we will provide your with one free copy of your PHI. You will have to pay for any additional copies. Costs of additional copies of your PHI are:

A. Set of x-rays: $25.00

B. Treatment notes: $1.00 per page

C. Postage costs necessary to mail these copies to you

You may request that we provide copies in a format other than photocopies , but we cannot guarantee that we can accommodate your request for anything other than photocopies.

Barth Family Dentistry, PSC may deny you access to you PHI, without providing you an opportunity for review, in the following circumstances:

A. Access to health information may be denied if the PHI was obtained from someone other than a healthcare provider under a promise of confidentiality, and if the access requested would reasonably be likely to reveal the source of information.

Barth Family Dentistry, PSC may deny you access to your PHI (but with the opportunity for review) I the following circumstances:

A. A licensed healthcare professional has determined that , in their professional judgment, the request is likely to endanger the life or physical safety of the individual or another person.

B. The health information makes reference to another person, other than a healthcare provider, and a licensed healthcare professional has determined that, in their professional judgment, that access requested is reasonably likely to cause substantial harm to the other person.

C. The request for the access is made by the individual's personal representative and a licensed healthcare professional has determined that, in their professional judgment, access is reasonably likely to cause substantial harm to the individual or another person.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for the last 6 years, but not before April 14, 2003. Exceptions to this right are disclosures that were made:

A. To carry out treatment, payment, and in support of healthcare operations.

B. For national security or intelligence purposes

C. To correctional facilities or law enforcement officials

D. Prior to the compliance date of this Notice.

If you request this accounting more than once in a 12 month period, we may charge you're a reasonable, cost-based fee for providing your with accounting of your PHI.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are <u>not</u> required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

A. You **MUST** notify Barth Family Dentistry, PSC of your wish to limit disclosure of your PHI in writing and explain in detail the nformation that you would like to have restricted.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your PHI by alternative means or to lternate location within the office. You must make your request in writing. Your request must specify the alternative means and/or location, and provide satisfactory explanation as to how payments will be handles under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances as follows:

A. The information was not created by Barth Family Dentistry, PSC, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment.

B. Your health information is not part of our record.

C. Your health information is accurate and complete.

ELECTRONIC NOTICE: If you receive this Notice on our Website or e-mail, you are entitled to receive this Notice in written form.

PATIENT'S RESPONSIBILITY: You, the Patient and/or Legal Guardian, are responsible to read and stay current on the most current postings/changes of the Privacy Policy updates and addendums, which will be posted in plain sight in a folder in the waiting room for all to read. This folder is not to be removed for this waiting room. Any updates or addendums will be posted immediately following the this privacy notice. We will provide a copy to you of the privacy notice and all updates and addendums upon your request.

<u>QUESTIONS AND COMPLIANTS</u>:

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use of disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint t the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your PHI. 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.

<u>**Ask the Privacy Officer for a complaint form to fill out!!**</u> **BARTH FAMILY DENTISTRY,PSC**

Privacy Officer: Rhonda Stephenson :
1821 Florence Pike St 2, Burlington, KY 41005
Phone: (859) 689-7700 Fax: (859) 689-9641

Updated Jan 1, 2016