

Collins Family Dentistry
Kyle B. Collins D.M.D.
301 E Ash Street
Caldwell, ID 83605

Date: _____

PATIENT NAME: _____

Birthdate: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____

Whom may we thank for referring you to our office? _____

Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Soc. Sec: _____

E-mail: _____

Employer: _____ Phone: _____

Address: _____

City, State, Zip: _____

Receipt of Notice of Privacy Practices: Written Acknowledgement Form

I acknowledge I have had the opportunity to read the Notice of Privacy Practices of Collins Family Dentistry and a copy was made available to me.

_____ Date _____

Signature of Patient or Personal Representative

If Personal Representative's signature appears above, please describe relationship to patient: _____

Patient Name: _____ Patient Birthdate _____

FINANCIAL POLICY

Before seeing Doctor, please tell office staff if you need to make financial arrangements. In accordance with the Federal-Truth-In-Lending Act, which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies, which apply in this office. The responsible party agrees to the following:

1. Payment in full of all fees the date of treatment by check or cash with a 5% discount.
2. Master Card or Visa is accepted, no discount given.
3. Financing Available through Care Credit.
4. Insurance will be billed for you; all amounts not paid within 45 days or denied by the insurance company are your responsibility and must be paid immediately.
5. I am aware that any account balance not paid within 30 days from the date of first billing, will be accessed a finance charge of 1.5% per month on the unpaid balance (annual rate of 18%).

Responsible Party Signature _____ Date _____

MEDICAL HISTORY

PATIENT NAME _____ BIRTHDATE _____

PERSON TO CALL IN CASE OF EMERGENCY _____

Are you under a physician's care now? Yes No Name _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
Do you take vitamins, alternative or herbal medicines? Yes No _____
Do you use Tobacco Yes No Are you interested in a smoking cessation program? Yes No
Do you use controlled substances? Yes No _____
Women: Are you Pregnant? Yes No _____
Have you had any reactions to metals in jewelry? Yes No List _____
Are you allergic to any of the following?
 Aspirin Penicillin Codeine Novacaine/Local Anesthetics Latex Others _____

Do you have or have you had, any of the following? **Circle all that Apply**

Heart Trouble/Disease Surgical Joint Replacement Cancer Venereal Disease
Heart Valve Replacement Asthma Chemotherapy Syphilis
Heart Murmur Seizure Radiation Treatments Gonorrhea
Heart Attack Last Seizure _____ Diabetes Chlamydia
Heart Pace Maker Low Blood Pressure Kidney Disease Herpes II
High Blood Pressure Allergies Liver Disease AIDS/HIV Positive
Rheumatic Fever Glaucoma Hepatitis A,B,C Tuberculosis
Irregular Heartbeat Drug Addiction Cirrhosis

Have you ever had any serious illness not listed above? Yes No _____

Have you taken or are you taking any of the following? **Circle all that Apply**

Aredia Zometa Methotrexate Fosamax (alendronate) Fosamax with Vit D Actonel (Risendroonate) Actonel with Calcium
Boniva (Ibandronate) Evista Forteo IM Skelid (Tiludronate) Didronel (Etidronate)

Do you take any pills or medications now? Yes No Do you take aspirin? Yes No

List Current Medications _____

DENTAL HISTORY

Who was your last dentist? _____

Date of your last dental exam, cleaning, x-rays? _____

Do you have sores inside your mouth Yes No _____
Any history of bleeding gums? Yes No _____
Have you ever had a jaw or mouth injury? Yes No _____
Are you having any discomfort or pain? Yes No _____
Are you aware of any dental problems? Yes No _____
Have you ever fainted or become nauseous during dental treatment? Yes No _____
Have you ever experienced any illness or complications following dental treatment of any kind? Yes No _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I the undersigned (patient or legally responsible party) authorize dental treatment to be rendered by the dentist and his staff, and assume financial responsibility.

Signature Date

Health History Update: I have reviewed the above medical history. My health and medications have changed as follows:

Date Changes Patients Initials Reviewed By

INSURANCE INFORMATION

Person Responsible for Acct: _____
Address _____
City _____ State _____ Zip _____
Phone _____ Birthday _____ SS# _____

PRIMARY INSURANCE INFORMATION

Subscriber _____ SSN _____
Insurance ID Number _____ Birthdate _____
Employer Name _____
Address _____
City _____ State _____ Zip _____
Insurance Company Name _____
Address _____
Group # _____ Phone _____

SECONDARY INSURANCE INFORMATION

Subscriber _____ SSN _____
Insurance ID Number _____ Birthdate _____
Employer Name _____
Address _____
City _____ State _____ Zip _____
Insurance Company Name _____
Address _____
Group # _____ Phone _____

Dependent Children Covered:

Name/Birthdate _____ Name/Birthdate _____
Name/Birthdate _____ Name/Birthdate _____

Release of Information Authorization:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and for dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits to the insurance carrier for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. This authorization may be revoked by written notice by the covered person/employee to the dentist and or to the insurance company.

Authorized Signature _____ Date _____

Assignment of Benefit Authorization:

I hereby agree that the insurance carrier shall pay Collins Family Dentistry any dental care benefits to which I may be entitled and I assign all of my rights, title and interests in such benefits to Dr. Collins for:

____ All services Performed today and in the future. _____ Date of Service Only
____ Course of the Treatment Plan Beginning _____ Ending _____

Authorized Signature _____ Date _____

Benefits:

Deductible _____ Preventative _____ Basic _____ Major _____

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

COLLINS FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until 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 the 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 upon request.

You may request 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 AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information 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 an authorization, you may revoke it in writing at any time. Your revocation 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 health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

SUD Treatment Information: If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose you Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a

format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.____ for each page, \$____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

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.

QUESTIONS AND COMPLAINTS

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 health information or in response to a request you made to amend or restrict the use or disclosure of your health information 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 to 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 health 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.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____