Valentine
DENTAL CARE™

KID'S FORM

Treatment will not begin unless this form is completed in its entirety.

Today's Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY 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 provide this notice to you regarding our privacy practices, legal duty, and your rights concerning your healthcare information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ***August 14, 2002,*** and will remain 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. Please contact us using the information listed at the end of this Notice for more information about our policy, or for additional copies.

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 or disclose your health information to obtain payment for the services we provide to you.

Healthcare Operations: We may use or 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 healthcare 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 authorization, you may revoke it 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 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, 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 judgement 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 and 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 healthcare information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional Institution or law enforcement officials 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).

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 predictably 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 upon the 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 $1.22 for each page, up to $25.00 by complying with the Michigan Medical Records Act from April 1, 2004* including processing (this is at no profit). 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 disclose your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before August 14, 2002. 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 that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing with date& time). 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.

Today's Date: _____

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail)m you are entitled to receive this Notice in written form.

If you want more information about our privacy practices, or have questions, 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 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 the right to the privacy of your health information. We will not hesitate 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: Anthony Valentine D.D.S.
Telephone: (734) 662-6772
Fax: (734) 662-6778
Address: 1121 E. Stadium Blvd.
Ann Arbor, MI 48104

Valentine Dental Care
Children's Health History Form

Full Legal Name: _____

Preferred Name: _____

Date of Birth:_____ Which Parent to contact for Dental:_____

Mother's Full Name:_____ Father's Full Name:_____

Name of previous dentist/location: _____

Date of last dental examination: _____Childs Weight: _____

Date of last cleaning: _____Childs Height: _____

Why have you come to see us today (e.g. pain, checkup, etc.)? _____

_____

How did you hear about us? _____

Family physician (name, location, contact info, and last visit): _____

_____

Today's Date: _____

Personal Contact Information of Legal guardian:

Home Address:_____

City:_____ State:_____ Zip Code:_____

Main Phone #: _____ E-Mail:_____

Please remind me of my next dental appointment via (check all that apply):

_____ Mail _____ E-mail _____ Phone

Social Security# for patient and subscriber: _____

Employer: _____ Work Phone #:_____

Emergency Contact Person: _____

Relation: _____ Phone #:_____

Dental Insurance Information

Subscriber's Name:_____

If you are a dependent of the subscriber, please list your name: _____

Subscriber's ID#:_____Subscriber Birth Date:_____

Group #:_____Subscriber Phone#:_____

Subscriber's Employer:_____

Insurance Company Name and Address:_____

_____

_____

We require a copy of 2 forms of ID (Drivers License, library care, Credit Card & Dental Insurance Card) for all patients. YOU MUST READ AND SIGN ALL PAGES. Thank you.

Today's Date: _____

Patient Consent

The undersigned hereby authorizes Valentine Dental Care, LLC office to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, therapy and medication that may be indicated and further authorize and consent that the doctor choose and employ such assistance as is deemed appropriate. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility of dental services provided in this office for myself or my dependents is payable at the time services are rendered.

Additionally, I authorize and legally give permission as the legal guardian for emergency contact for my child to be _____ whom is _____ related to my child.

The parent to speak with regarding treatment is :_____ and whos position of relation to my child is _____.

The emergency contact form my child is _____ (Phone)_____

Date

X_____ _____

Parent/Guardian Signature

Today's Date: _____

Dental Health History:

Yes	No	
☐	☐	Who brushes your childs teeth? How often? _____
☐	☐	Who flosses the childs teeth? How often? _____
☐	☐	Any pain or discomfort at this time?
☐	☐	Do their gums bleed while brushing or flossing?
☐	☐	Are there any loose/ wiggly teeth?
☐	☐	Any sensitive teeth to hot or cold liquids/foods?
☐	☐	Have there ever experienced any of the following problems with your childs jaw?
		If yes, please circle all that apply:
		Clicking Pain Difficulty When Opening/Closing Difficulty in Chewing
☐	☐	Does the child use any fluoride products or fluoride rinses? If yes, what?_____
☐	☐	Does the child clench or grind their teeth? If yes, when? _____
☐	☐	Have you ever been informed about orthodontic treatment? Do they wear a retainer? ☐ YES ☐ NO
☐	☐	Any facial surgery or facial trauma? If so, when and what area of your face?
		_____
☐	☐	What are some common foods/drinks/ and snacks that you feed your child?
		_____
☐	☐	Are you or your child nervous about dental treatment?

If needed, please provide any additional information regarding your dental health history below or information that should be taken into account when planning your dental treatment:

_____

_____

_____

_____

Medical Health History:

Is your child allergic or ever reacted adversely to any of the following (check all that apply):

_____Aspirin
_____Codeine
_____Nitrous Oxide
_____Penicillin
_____Erythromycin
_____Other antibiotics _____
_____No Known Drug Allergies

___ Ibuprofen
___ Sulfa Drugs, Sulfites, Sulfides
___ Acetaminophen/Tylenol
___ Barbiturates
___ Tetracycline
_____Local Anesthesia (Novocaine)
_____Latex, Metals, Plastic

Please list any other medical, drug, or other allergies below:

_____

Today's Date: _____

Check any of the following that your child has or has had:

_____Osteoporosis
_____Heart disease or heart attack
_____Abnormal blood pressure (High or Low)
_____Heart murmur/mitral valve prolapse
_____Rheumatic fever
_____Heart pacemaker
_____Heart surgery
_____Stroke
_____Kidney disease
_____Autism
_____Arthritis
_____Anemia
_____Bleeding disorders
_____Hay fever
_____Ulcers
_____Jaundice
_____Herpes
_____Tumor or malignancy
_____Radiation treatment
_____Blood transfusion
_____Fainting
_____Headaches
_____Glaucoma
_____Chicken Pox

___ Bisphosphonate therapy (e.g. Boniva)
___ Asthma
___ Diabetes
___ Thyroid issues
___ Hepatitis A, B, C
___ Hemophilia
___ Epilepsy or seizures
___ Psychiatric treatment
___ Hypertension
___ Anything not listed
___ AIDS or HIV+
___ Congenital heart lesions
___ Tuberculosis or lung disease
___ Sinus issues
___ Liver disease
___ Infectious mononucleosis (mono)
___ Sexually transmitted/venereal disease
___ Cancer/chemotherapy/radiation
___ Implants/artificial joints
___ Anaphylaxis
___ Allergies (including food)
___ Hard of hearing
___ Sickle cell disease/traits
_____ Anything not listed:_____

Other(include if smoking household): _____
_____

Major surgeries (type and year): _____
_____
_____

List sports activities: _____
_____
_____

Today's Date: _____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements.

Name of medication	Dosage in MG	Number of times taken	When
i.e. Lisinopril	*50*	*1x*	*As Needed*

Yes	No	
☐	☐	Has child been hospitalized during the past two years?
☐	☐	Has child been asked by their medical doctor to premedicate before any dental treatment?
☐	☐	If female, could child be pregnant or is child pregnant?
☐	☐	Has child had HPV vaccination?

Authorization: I confirm that the information on this form is accurate. I understand that this information will be used by the dentist to help determine my dental treatment. If there is any change in my childs medical status, I will inform the dentist. I certify that I have fully read and understood all of the above. I acknowledge that my questions, if any, about the inquiries set forth above, especially those regarding my child, have been answered to my satisfaction. I will not hold my dentist or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form, especially those regarding my child; the patient, and understand the HIPAA regulatory laws.

Printed Parent/Guardian Name: _____

Signed Parent/Guardian Name: _____Date: _____

Childs (patient) Printed Name:_____

Doctor Signature:_____Date:_____

Today's Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Legal Name: _____

Address: _____ City: _____

Zip Code: _____ Phone #: _____ Social Security #: _____

****

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes or revisions. Those revisions may apply to any of your health information, which we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Anthony Valentine, D.D.S. Telephone: (734) 662-6772 Fax: (734) 662-6778

Address: 1121 E. Stadium Blvd. Ann Arbor, MI 48104 E-mail: info@valentinedentalcare.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent prior to receiving your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected healthcare information to carry out treatment, payment activities, and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: _____

Relationship to Patient:_____ Authority:_____

Today's Date: _____

CONSENT FOR COMPOSITE FILLINGS

After completing your exam and X-rays, the doctor may diagnose the need for a filling, or fillings, to help eliminate cavities and improve oral health. A cavity will never go away on its own. There are different types of filling materials that can be used. Two of the most common filling materials are Amalgam and Composite. Below are some facts regarding each. Please note that we are an amalgam free office and only place composite resin fillings:

AMALGAM: *The historic and traditional silver filling material.*
According to the American Dental Association, Amalgam is:

- Metal alloy (silver color) including copper, tin, silver, mercury, and others
- Not a hazard
- Durable for chewing
- Partial to potential sensitivity to cold (metal conducts temperature)
- Less expensive and most insurance companies cover expected percentage.

COMPOSITE: *Tooth colored filling material*
According to the American Dental Association, a Composite is:

- A white colored substance, which bonds to teeth
- Made with a composite of materials including ceramic particles (metal sparing fillings)
- Partial to potential tooth sensitivity (temperature and other)
- Susceptible to needing replacement earlier than amalgam fillings
- Normally **not** covered, or partially covered by insurance. Therefore, all composite fillings will cost approximately $45.00 more per tooth (and depending on insurance).

By signing below, I state that I have read this form and have had any questions, answered. I also have researched the information provided and understand that my insurance company may change coverage for filling types.

Printed Patient Name: _____

Patient Signature: _____

Date: _____

Today's Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgment

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

Signature: _____

Date: _____

****FOR OFFFICE USE ONLY****

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please Specify)

_____
_____
_____

Today's Date: _____

VALENTINE DENTAL CARE, PLLC COMPLETED FORM REQUIRED PRIOR TO TREATMENT INITIATION

FINANCIAL POLICY

We at Valentine Dental Care, PLLC pride ourselves in serving the community providing the finest and most comprehensive dental services possible. Following diagnosis, the doctor will advise you of our plan of treatment. Additionally, we can discuss finances with you per your request- including today's costs and costs of any future treatment plan that were discussed during your visit.

INSURANCE

We are here to help and will process your insurance claims for you. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by one of the options listed below. The estimates are subject to change depending on acceptance and approval by your insurance company or treatment changes; therefore, the amount owed to our office for services is subject to change. Please remember that we are not the insurance company and we can only provide ESTIMATES regarding benefits and coverage. Detailed questions may require you contacting your insurance company or human resource individual. Please contact your insurance company to verify benefit coverage amounts. We are often given the incorrect information or not informed if dental work has been completed or undertaken in another office. It is the patient/guardian responsibility to pay off the balance if the insurance company has not paid after 60 days past services rendered.

PAYMENT

Payment is required at time of visit for all patients. Payment for today's visit and future visits are due at the time of treatment plans. We are sensitive to the fact that some people may not be able to pay in cash at the time of treatment. For this reason, we have added Care Credit as an option for treatment payment in our office. We reserve the right to charge interest in the amount of 1.5% (18% APR) on any unpaid balances after 60 days. See receptionist for Care Credit details. No American Express. For services rendered to a minor, the adult accompanying the minor, and the parent/guardian with custody will be responsible for the payment. A Patient credit card or cash will be utilized to settle all balances. Please provide your Credit card information below and note that signing gives Valentine Dental Care, PLLC authorization to settle outstanding balances from your account including all minors. Please check one below:

Credit Card We accept (please circle): VISA MasterCard Discover (We do not accept AmEx)
Card#_____ Exp Date:_____ :_____

_____I hereby authorize Valentine Dental Care, PLLC to process payments, from time to time, as the dental office deems necessary, to settle/pay my account in full with the information above. I understand that my credit card above will be used to settle all balances on my account and provide authorization.

Printed Patient Name:_____

Patient Signature:_____Date:_____

_____I hereby authorize Valentine Dental Care, PLLC to process payments to settle/pay my account in full but will pay by cash or cashier check prior to treatment start on the date of my appointment. I understand that estimated balances may be used.

Printed Patient Name:_____

Patient Signature:_____Date:_____

In the event that your account is placed with a third party collections agency or an attorney, you will be assessed all fees that pertain to this collection process.

Today's Date: _____

BROKEN APPOINTMENT POLICY

Our office requires a minimum 24 hour notice for cancellation of an appointment. We do not accept voice message cancellations including after hours. There is a $50.00 per half hour charge for appointments, which are cancelled or missed without proper notice.

Thank you,

Valentine Dental Care, PLLC

By signing below, you acknowledge our Broken Appointment Policy and adhere to the conditions.

Printed Name: _____

Signature: _____

Date: _____

Today's Date: _____

Information About Dental Insurance

Dental insurance benefits can cause a great deal of confusion for some patients. Unlike medical insurance, which often has a set co-pay and/or percentage coverage without a maximum allowance, dental insurance benefits often are based upon a random formula and include a maximum amount of coverage. This below attempts to explain some of the most misunderstood features of a dental plan.

UCR (Usual, Customary, Reasonable)
UCR is the maximum amount your insurance plan will pay for a procedure. It is based upon a percentage formula set by the individual insurance company and is not always based upon actual average dentists' fees in your area. The patient is responsible for the costs above the UCR level.

Preferred Providers
Your plan may encourage you to go to a dentist on its list of preferred providers. Most plans allow you to see any dentist you would like, regardless of whether the dentist is on the list. However, your benefits may be different when you visit an out of network dentist.

Pre-Existing Conditions
Some dental insurance plans do not cover conditions that existed prior to enrollment. One example is a "missing tooth clause," which will not pay for the replacement of a tooth that was missing prior to the beginning of coverage.

Frequency Limitations
Some plans set limits on certain procedures and those procedures may not be covered by your insurance as often as they are dentally necessary. Some common examples include only allowing for sealants once in a lifetime when sealants generally last only 3 — 7 years. Other patients may need dental cleanings more than the two times per year that their plan allows.

Deductibles/Percentage Covered
Most plans have a deductible amount, which the patient pays before any benefits begin. This is a one-time fee each benefit year. In addition, insurance plans set a percentage of costs they will cover for each type of treatment. For example, an insurance company may cover 100% of preventative work (exams, cleanings, etc.), 80% of basic restorations like fillings and 50% of major restorations like crowns.

Yearly Maximums
Almost all plans will have an annual maximum benefit and many times this amount is as low as $1,000 — $3,000. Your plan will not pay more than this set amount in any given benefit period (typically a year). Patients are responsible for charges above this maximum.

Treatment Exclusion/Wait Periods
Certain plans will not cover some procedures, such as sealants, implants and orthodontics. Dental plans may also place a waiting period on some procedures. For instance, your plan may require you to wait six months for a crown to be a covered service.

Alternative Treatment
Often dental insurance plans will only cover the least expensive treatment possible. For example, many plans only cover the cost of mercury amalgam silver fillings instead of tooth-colored composite fillings. The insurance company will pay its set UCR for an amalgam filling and the patient will pay the difference between the cost of the amalgam and the cost of a composite filling. Many times the least expensive alternative treatment is not the best choice for optimal dental health. Patients need to choose what is best based upon their needs, not their insurance coverage.

Get The Care You Need
When considering all of this information, it is important to remember that you may need dental care that falls outside of your plan benefits or at a time when you have reached your maximum allowance. In order to avoid future dental complications that could require more extensive (and expensive) treatment later, patients always need to make decisions that are in the best interest of their dental health and seek treatment in a timely fashion.