Deer Run Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

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

_____

_____

_____

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

Financial Arrangements

All patients please read the following…

Payment for services is expected at the time service is provided unless other arrangements have been made in advance. Cash and personal checks are accepted as well as MasterCard, Visa and American Express credit cards. If an extended payment plan is desired, please ask us about Care Credit payment plans.

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 35% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee. A $35 charge will be assessed for each check returned to us by the bank as unpaid. If the account is in default and turned over for collection, a collection fee of 25% will be added.

If you have dental insurance

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. **Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly**. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

48 Hours Notice Policy

48 business hours notice is required for all rescheduled or cancelled appointments. You will be charged a fee of $50 per hour based on the number of hours of the rescheduled or cancelled appointment if the required notice is not given.

_____ _____

Signature Date

Deer Run Dentistry

Patient Information

Name: Last First Middle	**I Prefer to be called:**	**Sex:** ☐ Male ☐ Female	
Address: Street/PO Box City State Zip	Phone Numbers Work: Home: Cell:		
E-mail Address	**Date of Birth**	**Social Security No.(If Child, Parent's SS#)**	
Occupation	**Employer**	**How long employed?**	**Address & Phone No.**
Person responsible for bill	**Social Security No.**	**Relationship**	**Address & Phone No.**
Occupation	**Employer**	**How long employed?**	**Address & Phone No.**

Insurance Information

Insured Person's Full Name			
Social Security Number	**Relationship to Patient**	**Work Phone**	**Cell Phone**
Insurance Company Name	**Group Number**	**Member ID Number**	
Employer Name	**Full Address of Employer**		

Whom may we thank for referring you? _____

Is there another member of your immediate family or a relative a patient in our practice? _____

Emergency Contact:_____ **Relationship:** _____ **Phone Number:** _____

Are you covered under more than one dental plan? ❑ No ❑ Yes

If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist in verifying the coverage that your particular program provides. We accept assignment of your insurance payments, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason does not honor their commitment to you and to us.

FOR ALL PATIENTS:

I herby authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or her staff. I agree to pay a minimum monthly billing charge of $10 or interest at the rate of 1.5% per month (whichever is greater) on any balance not paid within 30 days of the date of service.

Signature of responsible party_____ Relationship_____ Date_____

ASSIGNMENT & RELEASE:

I the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Deer Run dentistry all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.

Signature of responsible party_____ Relationship_____ Date_____

Deer Run Dentistry Dental Information

Patient Name: _____

Are you having a dental problem that requires immediate treatment? _____

How do you feel about the appearance of your teeth? If you could change anything, what would you change?_____

_____

Date of last dental cleaning: _____ Date of last full set of x-rays: _____

Date of last dental appointment: _____ What was done at that time: _____

Name of previous dentist: _____ Phone #: _____

Address: _____

Reason for leaving previous dentist: _____

Do you feel nervous about having dental treatment? ❑ No ❑ Yes-- Describe: _____

Have you ever had an upsetting dental visit? ❑ No ❑ Yes-- Describe: _____

Are you interested in or do you need nitrous or oral sedation? ❑ No ❑ Yes-- Describe_____

Are any of your teeth sensitive to:	**How often do you:**	**Do you use:**
Hot or cold ❑ Yes ❑ No	Floss: ____times/week	A Powered Toothbrush ❑ Yes ❑ No
Sweets ❑ Yes ❑ No	Brush: ___ times /day	Type and Frequency:_____
Biting/Chewing ❑ Yes ❑ No	WaterPik: ___times/week	Mouthwash: ❑ Yes ❑ No
		Type: and frequency: _____

Are you happy with the color of your teeth?.....❑ Yes ❑ No Describe: _____

Do your gums bleed or hurt?.....❑ Yes ❑ No Describe: _____

Do you have any loose teeth?.....❑ Yes ❑ No Describe: _____

Does food ever get caught between teeth?.....❑ Yes ❑ No Describe: _____

Do you bite your lips or cheek frequently?..... ❑ Yes ❑ No Describe: _____

Do you hold foreign objects with your teeth (pens, pipe, etc.)?.... ❑ Yes ❑ No Describe: _____

Do you mouth breath while awake or asleep?.....❑ Yes ❑ No Describe: _____

Do you have popping or clicking in your jaw?..... ❑ Yes ❑ No Describe: _____

Do you experience pain (jaw, joint, ear, or side of face)?..... ❑ Yes ❑ No Describe: _____

Do you have difficulty opening or closing your mouth?.....❑ Yes ❑ No Describe: _____

Do you have difficulty chewing on either side of your mouth?.....❑ Yes ❑ No Describe: _____

Do you have tired jaws, especially in the morning?..... ❑ Yes ❑ No Describe: _____

Do you get tension headaches?..... ❑ Yes ❑ No Describe: _____

Have you been told you clench or grind your?.....❑ Yes ❑ No Describe: _____

Have you had any teeth removed?.....❑ Yes ❑ No Describe: _____

Have you had orthodontic (braces) treatment?..... ❑ Yes ❑ No Describe: _____

If yes: Are you still wearing your retainers? .....❑ Yes ❑ No Describe: _____

Do you have a night guard? .....❑ Yes ❑ No Do you wear it? _____

Have you had periodontal treatment? .....❑ Yes ❑ No Describe: _____

Have you ever been told you snore? .....❑ Yes ❑ No Describe: _____

Have you ever been told you have bad breath? .....❑ Yes ❑ No Describe: _____

Do you have problems with dry mouth? .....❑ Yes ❑ No Describe: _____

Deer Run Dentistry Health Information

Please complete the following confidential form. The information provided is important to your dental health.

Patient Name: _____

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Addiction OR Chemical Dependency
- ❑ Acid Reflux or GERD
- ❑ Allergies OR Hives
- ❑ Alzheimer's Disease
- ❑ Angina (Chest Pain)
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valve (Date:_____)
- ❑ Artificial Joint (Date/Type:_____)
- ❑ Asthma
- ❑ Autoimmune Disorder (Type: _____)
- ❑ Blood Transfusion
- ❑ Bruise Easily
- ❑ Cancer (Date/Type:_____)
- ❑ Chemotherapy OR Radiation Treatment
- ❑ Cold Sores/Herpes/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ COPD OR Emphysema OR Bronchitis
- ❑ Cortisone Medicine
- ❑ Diabetes (Type:____)
- ❑ Depression OR Anxiety
- ❑ Eating Disorder (Type:_____)
- ❑ Epilepsy, Seizures, OR Fainting
- ❑ Genital Herpes
- ❑ Glaucoma OR Macular Degeneration
- ❑ Heart Attack or Heart Disease
- ❑ Heart Pace Maker
- ❑ Hemophilia
- ❑ Hepatitis A, B, or C
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ HIV Positive OR AIDS
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Metal Allergy
- ❑ Mitral Valve Prolapse
- ❑ Pain in Jaw
- ❑ Psychiatric Treatment
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Sleeping Disorder
- ❑ Stroke OR TIA (Date_____)
- ❑ Thyroid Disease
- ❑ Tuberculosis (TB)
- ❑ Ulcers
- ❑ Venereal Disease

List all PRESCRIPTION and OVER-THE-COUNTER medications you are taking:_____

_____

Do you have any disease or condition not listed? ____ If yes, please list: _____

_____

Have you had surgery or been under the care of a medical doctor in the past 2 years?

If yes, please describe:_____

Have you ever been told to pre-medicate with antibiotics prior to dental care? YES NO

Have you ever had excessive bleeding requiring special treatment? YES NO

Do you use, or have you used tobacco products? YES NO

Date/Type:_____

Do you use, or have you used recreational drugs? YES NO

Are you on Coumadin or other blood thinners? YES NO

Physician Name: _____ Phone Number :_____

Physician Address: _____

Are you allergic to or made sick by:

- ❑ Latex Materials
- ❑ Metal: (Type:_____)
- ❑ Penicillin
- ❑ Local Anesthetics ("Novocain")
- ❑ Codeine or other Narcotics
- ❑ Sulfa Drugs
- ❑ Barbiturates (sleeping pills),
- ❑ Aspirin
- ❑ Tetracycline
- ❑ Clindamycin
- ❑ Other: _____

For Women, are you:

- ❑ Pregnant? Delivery Date:_____
- ❑ Breastfeeding
- ❑ Taking Birth Control Pills
- ❑ On Medication for Menopause

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency to release information to you.

Signature of Patient (OR Parent) _____ Date: _____

*Provider's Notes:*_____

_____

_____

_____

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 April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and 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 by using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use or 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 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 professions, 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 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 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, counter intelligence, 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).

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 your 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 $.90 for each page, $10 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 alternate 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 sign 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 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 may also submit a written complaint with 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.

Deer Run Dentistry
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