NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement

officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Official
David Quigley
6240 Lake Osprey Drive
Sarasota, FL 34240
Ph #: (941) 955-3150

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Patient Consent to receive Mail, E-mail and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

I agree that the practice may communicate with me electronically at the following address:

E-mail Address *(please print)*

Do we have your permission to:

Send a recall appointment reminder to your home? Y_____ N_____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y_____ N_____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____
Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Please provide us with the best phone number(s) to reach you at in the event of bad weather.

Phone Number(s)_____

Acknowledgment of Receipt of Notice of Privacy Practices

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

_____ _____
Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

HIPAA CONSENT

FOR OFFICE USE ONLY

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

☿ Patient / Parent or Legal Guardian refused to sign form

_____ _____
Signature of Office Manager Date

☿ Other

_____

Today's Date:_____ **Today's BP** _____/_____

PATIENT NAME _____ **DATE OF BIRTH**_____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care_____

Former Dentist _____ Date of last dental X-rays_____

Address_____

Home Phone_____Cell Phone_____E-mail Address_____

How did you find out about our office?_____

Are you satisfied with your smile? ☐ YES ☐ NO If not, do you want to improve it? ☐ YES ☐ NO

Check (✓) YES/ NO if you have had problems with the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Bad breath	☐	☐	Grinding teeth	☐	☐	Sensitivity to cold	☐	☐	Sores or growths in mouth	☐	☐
Bleeding gums	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity to hot	☐	☐	Swelling	☐	☐
Clicking or popping jaw	☐	☐	Pain	☐	☐	Sensitivity to sweets	☐	☐	Reaction to local anesthetic	☐	☐
Food collecting between teeth	☐	☐	Periodontal treatment	☐	☐	Sensitivity when biting	☐	☐			

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name_____Phone Number_____

Have you had any serious illness or operations? ☐ YES ☐ NO If yes, describe_____

Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, give approximate dates_____

Gender: ☐ Male ☐ Female **(Women)** Are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Check (✓) YES/NO if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Anemia	☐	☐	Cortisone Treatments	☐	☐	Jaw Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis, Rheumatism	☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Snoring	☐	☐
Artificial Devices or Joints	☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Fainting	☐	☐	Nervous System Problems	☐	☐	Swelling Feet /Ankles	☐	☐
Autoimmune Conditions	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐	Thyroid Problems	☐	☐
Bleeding Problems	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tobacco Habit	☐	☐
Blood Disease	☐	☐	Heart Problems	☐	☐	Psychiatric Treatment	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Radiation Treatment	☐	☐	Ulcer	☐	☐
Chemical Dependency	☐	☐	Hepatitis	☐	☐	Respiratory Disease	☐	☐			
Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath	☐	☐			
Circulatory Problems	☐	☐	HIV/AIDS	☐	☐	Skin Rash	☐	☐			

OTHER_____

MEDICATIONS

List of medications you are currently taking:

_____

_____

_____

Pharmacy_____ Phone_____

ALLERGIES

	YES	NO		YES	NO
Aspirin	☐	☐	Penicillin	☐	☐
Barbiturates (sleeping pills)	☐	☐	Sulfa	☐	☐
Codeine	☐	☐	Latex	☐	☐
Local Anesthetic	☐	☐	Other_____		

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
PLEASE PRINT NAME of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

_____ _____
Signature of Doctor Date

Today's Date:_____ **Today's BP** _____/_____

PATIENT NAME:_____ **DATE OF BIRTH**_____
Last First Initial

Address _____ Home Phone_____

_____ Cell Phone_____

E-Mail Address_____

MEDICAL HISTORY UPDATE

Physician's Name_____Phone Number_____

Have you had any serious illness or operations? ☐ YES ☐ NO If yes, describe_____

Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, give approximate dates _____

Gender: ☐ Male ☐ Female **(Women)** Are you pregnant? ☐ YES NO Nursing? YES NO Taking birth control pills? YES ☐ NO

Check (✓) YES/NO if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Anemia			Cortisone Treatments			Jaw Pain			Sleep Apnea		
Arthritis, Rheumatism			Diabetes			Kidney Disease			Snoring		
Artificial Devices or Joints			Epilepsy			Liver Disease			Stroke		
Asthma			Fainting			Nervous System Problems			Swelling Feet /Ankles		
Autoimmune Conditions			Glaucoma			Osteoporosis			Thyroid Problems		
Bleeding Problems			Headaches			Pacemaker			Tobacco Habit		
Blood Disease			Heart Problems			Psychiatric Treatment			Tuberculosis		
Cancer			Heart Surgery			Radiation Treatment			Ulcer		
Chemical Dependency			Hepatitis			Respiratory Disease					
Chemotherapy			High Blood Pressure			Shortness of Breath					
Circulatory Problems			HIV/AIDS			Skin Rash					

OTHER_____

MEDICATIONS

List of medications you are currently taking:

_____

_____

_____

Pharmacy_____ Phone_____

ALLERGIES

	YES	NO		YES	NO
Aspirin			Penicillin		
Barbiturates (sleeping pills)			Sulfa		
Codeine			Latex		
Local Anesthetic			Other_____		

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
PLEASE PRINT NAME of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

_____ _____
Signature of Doctor Date

DENTAL HEALTH HISTORY

PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

Has any member of your family ever been treated in our office ? ☐Yes ☐No

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

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ TELEPHONE _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No
☐Payment in full at each appointment (cash or personal check)
☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)
Card # _____ Exp. Date _____
☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section and sign/date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month or 18% APR
Collections fees (up to 42% of the full balance)
Legal fees for collection services

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Name Witnessed By