Carter Family Dentistry

General Dentistry

Patient Information

Patient Name: ______________________________ Date: ______________

Last First MI

Occupation: ______________ Employer: ______________ Title/Pos. ______________

❑ Male ❑ Female ❑ Single ❑ Married ❑ Child ❑ Other _______ Spouse's Name ______________

Social Security #: ______________ Birth Date: __________ Email Address: ______________

Phone: Home: ❑ ______________ Cell: ❑ ______________ Work: ❑ ______________ Please check preferred number

Address: ______________________________

City: ______________________ State: ______________ Zip: ______________

Emergency Contact: ______________________ Phone: ______________

Date of Last Dental Visit: ______________ Reason for today's visit: ______________________

Have you ever had any of the following? Please check those that apply:

❑ AIDS/HIV
❑ Alzheimer's Disease
❑ Anemia
❑ Arthritis
❑ Artificial Heart Valves
❑ Artificial Joints
Surgery Date: ________
❑ Asthma
❑ Blood Disease
❑ Cancer
❑ Diabetes
❑ Dizziness
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Fainting
❑ Glaucoma
❑ Growths
❑ Hay Fever
❑ Head Injuries
❑ Heart Disease
❑ Heart Murmur
❑ Hepatitis A, B, or C
❑ High Blood Pressure
❑ Jaundice
❑ Kidney Disease
❑ Liver Disease
❑ Mental Disorders
❑ Nervous Disorders
❑ Pacemaker
❑ Pregnancy at this time
Due Date: _________
❑ Radiation Therapy
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Rheumatism
❑ Sinus Problems
❑ Stomach Problems
❑ Stroke
❑ Tuberculosis
❑ Tumors
❑ Ulcers
❑ Venereal Diseases

- Please list all prescription and non-prescription drugs you are currently taking: ______________________
____
- Are you allergic to any of the following? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Latex ❑ Local Anesthetics ❑ Other ______________
- Do you use tobacco? ❑ Yes ❑ No
- Do you use controlled substances? ❑ Yes ❑ No
- Are you taking Coumadin or any other blood thinners? ❑ Yes ❑ No
- Have you ever had any complications following dental treatment? ❑ Yes ❑ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ❑ Yes ❑ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ❑ Yes ❑ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________ Phone: ______________
- Do you have any health problems that need further clarification? ❑ Yes ❑ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ ______________

Signature of patient or guardian Date

Referral Information

Whom may we thank for referring you to the practice? ❑ Friend ____________________(Name)
❑ Relative ____________________(Name) ❑ Dental Office ____________________(Name)
❑ Website ____________________ ❑ Other ____________________

Person Financially Responsible For Services
(if different from patient)

Date: ___/___/___ Age: _______ years Sex: ❑ Male ❑ Female Date of Birth: ___/___/___

Name: ____________________
Address: ____________________
City: ____________________
State: ____________ Zip: ____________

Social Security #: ____________________
Home Phone: ____________________
Work Phone: ____________________
Cell/Other Phone: ____________________

Marital status: ❑ Single ❑ Married ❑ Other Spouse's Name: ____________________
Is patient covered by dental insurance? ____________________
Please provide a copy of card and/or changes in dental insurance.

Policy Holder's Info

Name: ____________________ Relationship to patient: ____________________
Address: (if different from above) ____________________
City: ____________________ State: __________ Zip: ____________________
Phone: ____________________ Work: ____________________ Cell: ____________________

SS# ____________________ Date of Birth ___/___/___
Employer: ____________________ Title or Position: ____________________
Dental Insurance Co. Name and Address: ____________________
____
____
Phone # of Ins. Co.: ____________________
Policy #: ____________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for these dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefor the reasonable value of said services to said Doctor, or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected by me in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to consent. Signature: ____________________

Relationship to Patient: ____________________ Date: ____________________

CARTER FAMILY DENTISTRY

For Our Patients With Dental Insurance Coverage

We have always strived to assist our patients in every way possible to get the rightful coverage from their insurance carriers.

We will gladly file your claims, and assist you in getting payment from the insurance carrier. ***However, ultimately all services rendered are the responsibility of the patient and/or guarantor.*** We will research your benefits and give you our best estimate of what is "typically" paid by insurance carriers, but the payment by the carrier may be more or less than our estimate. Insurance carriers change, policies lapse, and numerous other factors beyond our control may alter the actual payment.

Policies are often based on "in" and "out" of network benefits. Some carriers pay the same benefits, others do not. We are typically "out of network" for most companies for the sole reason that we will not allow the insurance company to suppress the quality of care we provide for our patients.

There are literally hundreds of different dental insurance plans in our patient population, so it is not possible for us to know precisely what the benefits are for any given claim. In the final analysis, the compensation from a carrier is based upon the quality of the policy purchased by the employer or the patient.

I, ______________________________________have read and understand the above information.

Dated:____.

CARTER FAMILY DENTISTRY, LLC

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/01/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

<u>HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU</u>

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;

- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

<u>Other Uses and Disclosures of PHI</u>

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

<u>Your Health Information Rights</u>

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Concerns

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 if 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.

Our Privacy Official: Scott B. Carter, DMD

Telephone: 770-736-5545 Fax: 770-736-5265

Address: 1608 Tree Lane, Suite 203B, Snellville, GA 30078

E-mail: dr.cartersoffice@att.net

CARTER FAMILY DENTISTRY, LLC

Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

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 Below)