

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

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

Please Print Patient Name

Signature

Date

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:

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

4. For specific government functions: we provide information as required by military personnel and veterans in certain circumstances, which may include national security purposes.

I give my permission to Dental Solutions to disclose my or my child's health information to the following family member, friend, or other person. I understand that by signing this document that it will remain in effect until I revoke it in writing at any time. (Please list these persons below)

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. 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 the notice.

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.

Questions and Complaints: If you want more information about our privacy or concerns, please contact us. 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: Diana Hutchins

Phone: 601 925 5163

Fax: 601 925 5184

Address:

HIPPA 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.

This notice describes the privacy practices followed by all employees at the office of Dental Solutions of Clinton. We are required by law to maintain the privacy of protected health information (your dental records) and to provide you with notice of our legal responsibility and privacy practices with respect to your dental records. We do reserve the right to change the terms of this notice and make any revisions apply to all the dental records that we maintain. You will be notified of any changes in our practice.

There are many reasons for which we use and disclose health information. Some of these reasons may require you prior consent or specific authorization. Listed below are descriptions of different reasons of uses and disclosures of your medical information that may require your consent.

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. We may provide information from your dental record to our billing department, to your dental insurance plan or plans and to our business associates such as billing companies, claims processing companies or others that assist in processing our health care claims, in order to receive payment for the health care services our clinic provided you.

Your Authorization: In addition to our use of your health information for treatment or payment, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it in writing at any time.

To Your Family and Friends: We must disclose your health information to you. 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.

Person Involved In Care: We may use or disclose health information to notify, or assist in the notification of a family member, or person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure, we will provide you with an opportunity to object. 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 to make reasonable inferences of your best interest in allowing a person to pick up x-rays or similar forms of health information.

Normal Operations of this Clinic: We may disclose parts of your dental record in the normal operations of this clinic. These may include using a sign in sheet, providing you with appointment reminders such as voicemail messages, postcards, or letters, and calls about billing issues.

Listed below are uses and disclosures of your dental record that DO NOT require your consent.

1. For public health activities: we report information to the health department as it relates to any communicable disease such as tuberculosis.
2. As required by federal, state, or local law, judicial or administrative proceedings or law enforcement: we make disclosures or provide information from your dental record when the law requires that we report that information to government agencies or law enforcement personnel regarding abuse, neglect, or domestic violence.
3. For health oversight activities: we provide information as required to assist government agencies when they conduct an investigation or inspection of a health care provider or organization.

FINANCIAL AGREEMENT

DENTAL SOLUTIONS OF CLINTON, PLLC

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash
2. Checks
3. Visa, MasterCard, Discover
4. Care Credit

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment.

Parents accompanying their children are financially responsible for payment.

There is a **\$30.00** processing charge for **non-sufficient funds** or returned checks. **1 ½ % (18% annum) interest is charged on accounts with outstanding balances over 30 days.**

If account is sent to collection agency, there will be an addition 35% added to balance.

There will be a \$2 processing fee for monthly statements sent on balances over 30 days.

SIGN _____ **DATE** _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

**If account is sent to collection agency,
there will be an additional 35%
added to balance**

Consent for

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients 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 in cash 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.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this 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 therefore 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 to, 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 suit 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 payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code
E-Mail: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Have you had a joint replacement? No Yes If Yes please list date of surgery _____

• 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, parent or guardian _____ Date: _____

List of Daily Medications —and medical condition it is taken for (Please include Aspirin, Vitamins, and Herbal Supplements)

