RUTHERFORD COUNTY FAMILY & CHILDREN'S DENTISTRY

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.

If you have any questions about this Notice please contact the Privacy Officer.
Front Desk

Effective Date: July 1st, 2015

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.rcountydental.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you and leave you a message as a reminder about upcoming appointments or treatment. We may have a company confirm your appointments by email or text.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. You may contact the front desk at 828-375-0050 or bring your request in writing to: Rutherford County Family & Children's Dentistry.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Front Desk
828-375-0050

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on July 1st, 2015

Registration and Dental History

Patient's Name (First): (Last): (Middle Initial):

Preferred Name: Date of Birth: Age: Sex: **MALE FEMALE**

Address : City, State, Zip:

Cell Phone#: Work #: Other #:

E-Mail: Best Contact: **EMAIL TEXT CELL HOME**

Social Security#: Driver's License #:

Marital Status: **SINGLE MARRIED WIDOWED SEPARATED DIVORCED**

Spouse's Name or (If a minor) Parent's Name:

Spouse's Work Phone: Cell #:

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (if different from patient): Relationship:

Responsible Party Address, City, State, Zip:

Home Phone#: Work #: Cell #:

Employer: Employer Address:

INSURANCE & EMPLOYER INFORMATION

Insurance Carrier Name:

Subscriber's Name: Subscriber's Date of Birth:

Relation to Patient: **SELF SPOUSE CHILD OTHER** Subscriber's Phone #:

Subscriber's SS#: Insurance ID #: Group #:

Insurance Carrier Address, City, State, Zip:

Medicaid #:

Employment Status: **FULL TIME PART TIME UNEMPLOYED** Student Status: **FULL TIME PART TIME**

Employer: Phone #:

Employer Address, City , State, Zip:

DENTAL INFORMATION

Do your gums bleed when you brush?	**YES NO Don't Know**
Have you ever had orthodontic (braces) treatment?	**YES NO Don't Know**
Are your teeth sensitive to cold, hot, sweets or pressure?	**YES NO Don't Know**
Do you have earaches or neck pains?	**YES NO Don't Know**
Have you had any periodontal (gum) treatments?	**YES NO Don't Know**
Do you wear removable dental appliances?	**YES NO Don't Know**

How do you feel about the appearance of your teeth?

If you have a current dental problem, how would you describe it?

What was the name of your previous dentist? Office#:

Date of your last dental exam: Date of your last dental x-rays:

What was done at that time?

EMERGENCY CONTACT *

Emergency Contact: Phone/Cell #:

(Please list closest relative or friend whose address is different from yours)

Relationship to Patient:

Emergency Contact Address, City, State, Zip:

***Preferred Pharmacy:** ***Phone #:**

How did you hear about us?

Have you or another member of your family been treated here? If so, who?

Would you like to receive appointment reminders via text messages; **YES NO** via email? **YES NO**

Please Complete Both Sides

MEDICAL HISTORY

To help us to provide you with the safest and best care, please complete this Medical History form. All information is kept strictly confidential

Have you taken any prescription drugs during the last 6 months? Please list _____ **YES NO**

Are you taking any over the counter medications or herbal supplements? Please list: _____ **YES NO**

Are you under a physician's care? If so, name and phone # of Physician: **YES NO**

Have you had any surgeries and/or hospitalization? **YES NO**

Are you now having or have you ever had radiation to the head or neck? **YES NO**

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Please list: **YES NO**

Have you ever taken bone density medications for cancer or osteoporosis? **YES NO**

Have you ever or are you currently taking blood thinners? **YES NO**

Do you use tobacco? What type and how much per day? **YES NO**

Do you drink alcohol? If so, how much and how often? **YES NO**

Do you use "street drugs"? If so, which ones? **YES NO**

Are you pregnant? **YES NO** | Taking birth control? **YES NO** | Plan to become pregnant? **YES NO** | Nursing? **YES NO**

***Are you allergic to any of the following?** ◯ **NO KNOWN ALLERGY**

◯ Aspirin ◯ Penicillin ◯ Peanuts ◯ Codeine ◯ Acrylic ◯ Local Anesthetics
◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ **Other**_____

If condition applies please mark (YES) If condition does not apply please mark (NO):

AIDS/HIV Positive	◯ YES ◯ NO	Convulsions	◯ YES ◯ NO	Hemophilia	◯ YES ◯ NO	Recent Weight Loss	◯ YES ◯ NO
Alzheimer's Disease	◯ YES ◯ NO	Cortisone Medicine	◯ YES ◯ NO	Hepatitis Type_____	◯ YES ◯ NO	Renal Dialysis	◯ YES ◯ NO
Anaphylaxis	◯ YES ◯ NO	Diabetes	◯ YES ◯ NO	Herpes	◯ YES ◯ NO	Rheumatic Fever	◯ YES ◯ NO
Anemia	◯ YES ◯ NO	Drug Addiction	◯ YES ◯ NO	High Blood Pressure	◯ YES ◯ NO	Rheumatism	◯ YES ◯ NO
Angina	◯ YES ◯ NO	Easily Winded	◯ YES ◯ NO	High Cholesterol	◯ YES ◯ NO	Scarlet Fever	◯ YES ◯ NO
Arthritis/Gout	◯ YES ◯ NO	Emphysema	◯ YES ◯ NO	Hives/Rash	◯ YES ◯ NO	Shingles	◯ YES ◯ NO
Artificial Heart Valve	◯ YES ◯ NO	Epilepsy/Seizures	◯ YES ◯ NO	Hypoglycemia	◯ YES ◯ NO	Sickle Cell Disease	◯ YES ◯ NO
Artificial Joint	◯ YES ◯ NO	Excessive Bleeding	◯ YES ◯ NO	Irregular Heartbeat	◯ YES ◯ NO	Sinus Trouble	◯ YES ◯ NO
Asthma	◯ YES ◯ NO	Excessive Thirst	◯ YES ◯ NO	Kidney Problems	◯ YES ◯ NO	Spina Bifida	◯ YES ◯ NO
Auto-Immune Disease	◯ YES ◯ NO	Fainting/Dizziness	◯ YES ◯ NO	Leukemia	◯ YES ◯ NO	Stomach Disease	◯ YES ◯ NO
Blood Disease	◯ YES ◯ NO	Frequent Cough	◯ YES ◯ NO	Liver Disease	◯ YES ◯ NO	Intestinal Disease	◯ YES ◯ NO
Blood Transfusion	◯ YES ◯ NO	Frequent Headaches	◯ YES ◯ NO	Low Blood Pressure	◯ YES ◯ NO	Stroke	◯ YES ◯ NO
Breathing Problems	◯ YES ◯ NO	Genital Herpes	◯ YES ◯ NO	Lung Disease	◯ YES ◯ NO	Swelling of Limbs	◯ YES ◯ NO
Bruise Easily	◯ YES ◯ NO	Glaucoma	◯ YES ◯ NO	Mitral Valve Prolapse	◯ YES ◯ NO	Thyroid Disease	◯ YES ◯ NO
Cancer	◯ YES ◯ NO	Hay Fever	◯ YES ◯ NO	Osteoporosis	◯ YES ◯ NO	Tonsillitis	◯ YES ◯ NO
Chemotherapy	◯ YES ◯ NO	Heart Attack/Failure	◯ YES ◯ NO	Pain in Jaw Joints	◯ YES ◯ NO	Tuberculosis	◯ YES ◯ NO
Chest Pains	◯ YES ◯ NO	Heart Murmur	◯ YES ◯ NO	Parathyroid Disease	◯ YES ◯ NO	Tumors/Growth	◯ YES ◯ NO
Cold Sores/Fever Blisters	◯ YES ◯ NO	Heart Pacemaker	◯ YES ◯ NO	Psychiatric Care	◯ YES ◯ NO	Ulcers	◯ YES ◯ NO
Congenital Heart Disorder	◯ YES ◯ NO	Heart Disease	◯ YES ◯ NO	Radiation Treatment	◯ YES ◯ NO	Venereal Disease	◯ YES ◯ NO
						Yellow Jaundice	◯ YES ◯ NO

Other, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any changes in medical status.

Print Patient Name

Signature of Patient or Guardian Date

Rutherford County Family & Children's Dentistry
Financial Policy Agreement

Welcome to Rutherford County Family & Children's Dentistry. We appreciate your selecting us as your dental provider. We are committed to providing you and your family with the best possible service and appreciate the trust you have placed in our team of professionals. Before we perform any service, an explanation of your recommended treatment, treatment options, and a reasonable estimate of treatment fees will be presented to you for your approval.

We ask that you carefully review and sign our **Financial Policy Agreement** before beginning treatment, and we encourage you to talk with us regarding any problems that may affect your ability to afford care.

Payment for Services is expected at the time service is provided unless other financial arrangements have previously been made with our Office Manager. This includes any insurance, Medicaid, or other third party deductible or co-payment. We accept cash, personal check, money order, and most major credit cards.

Dental Insurance claims will be filed as a courtesy for most dental insurance plans provided that you have assigned benefits to Rutherford County Family & Children's Dentistry. Please contact your insurance carrier or consult your certificate of coverage for details pertaining to deductibles, co-payments, maximums, covered and non-covered services, and plan restrictions. Rutherford County Family & Children's Dentistry is a preferred provider for select insurance companies.

Please plan to bring a copy of your insurance card or verification of coverage to each appointment. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service.

Your insurance policy is a contract between you or your employer and the insurance company. Rutherford County Family & Children's Dentistry is not a party to that contract. Our relationship is with you, the patient, and not the insurance company. Therefore, you (or your account guarantor) are ultimately financially responsible for all services provided, including services that are not covered by your policy.

Miscellaneous Financial Information:

- Returned checks will result in an NSF fee of $25 charged to your account. Services to you and your family cannot continue until the returned check balance and NSF fee have been paid in full.
- Balances that are not current and are greater than 60 days past due may result in a loss of appointment privileges. Under these circumstances, emergency services will be available only on a fee for service basis.
- Balances that are not current and are greater than 60 days past due may result in loss of appointment privileges and are subject to transfer to a third party collections management company.

My signature acknowledges that I have read, understand, and accept these **Financial Policy Agreement** terms.

_____

Print Patient Name

_____ _____

Patient or Guardian Signature Date

Rutherford County Family & Children's Dentistry
Patient Appointment Agreement

Welcome and thank you for choosing Rutherford County Family & Children's Dentistry for your oral healthcare needs. We are committed to providing you with the best possible service and appreciate the trust you have placed in our team of professionals.

It is important for you to understand and agree to the following information to avoid any misunderstanding about our appointment policies.

Our office will only allow two failed/broken appointments before action is taken. A failed or broken appointment is defined as:

- Not showing up for your reserved appointment time.
- Arriving more than 10 minutes late for your reserved appointment time without prior notice.
- Calling to cancel your reserved appointment time with less than 24 hours notice.

If you fail two appointments as defined above, you will not be allowed to reserve future appointment. You will be able to call the day you would like to be seen. If our schedule allows, you may come in on the day you call.

Appointment Reminders

Appointment Confirmation: It is critical for us to be able to confirm your appointment before the scheduled date since many appointments are reserved weeks in advance. We will try to contact you two working days in advance of your scheduled appointment using your preferred method of communication documented in your Patient Registration form. ***Appointments that are not confirmed by noon the working day before the reserved time may be cancelled and another patient may be offered that appointment opportunity.***

Check-in: Please arrive 15 or more minutes before your reserved appointment time and check-in with the receptionist at your arrival time. You will be asked to pay your portion for services scheduled. Be prepared to provide a driver's license or photo ID or have your photo taken.

Check-out: Please check-out at the reception desk to schedule your next appointment.

Insurance: If you have dental insurance, please give us any written plan information you have been given by your employer so that we may help you maximize your insurance benefits.

Financial: All accounts must be current. Patients who have account balances 60 or more days past due may not be allowed to schedule appointments.

Rescheduling/Cancelling an Appointment: If you need to reschedule or cancel a reserved appointment, please contact our office.

I have read and understand the **Patient Appointment Agreement** and agree with its terms.

_____

Print Patient Name

_____ _____

Patient or Guardian Signature Date

Rutherford County Family & Children's Dentistry
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Rutherford County Family & Children's Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders
☐ Other person (s) (provide name and phone number) (**i.e. Spouse, Parent, Grandparent, Relative, Friend Etc.**) ☐ _____ ☐ _____ ☐ _____	☐ Financial ☐ Treatment
☐ Email communication - Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2014

Family Dentistry

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason: _____
- ☐ Other: _____

_____

Prepared By _____

Signature _____

Date _____

Rutherford County Family & Children's Dentistry
Parental Treatment Consent
For Child(ren) Under 18 Years of Age

I,_____, parent/legal guardian of the following:

Child(ren):

_____

give the below named person(s) permission to accompany my child to dental appointments, allowing them to make financial and treatment decisions on my behalf. I understand that medical history and consent must be updated and signed yearly by a parent or guardian. I understand that VERBAL CONSENT CANNOT BE ACCEPTED.

I understand that the person bringing the child must be 18 years or older, must be listed below and will be asked to show a valid picture ID.

I understand that a child under the age of 18 years old must be accompanied by an adult whose name is listed below.

I understand that in order to remove someone from this list a parent or legal guardian must come in person with valid ID and sign a new consent.

Person(s) and Relationship to Patient:

_____
Print Name Relationship

_____
Print Name Relationship

_____
Print Name Relationship

_____
Parent/Legal Guardian Signature: Date: