Patient Information

124 Timber Drive
Dayton, TN 37321

Medical Alert for Office Use

Thank you for visiting Today's Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Name _____ Preferred Name_____

Address _____ City_____

Zip_____ Employer_____

Drivers License State ____ Number: _____

Birth date_____ Height_____ Weight_____

Phone: Home ( ) _____ Work ( )_____

Mobile ( )_____ Social Security # _____

Email address: _____

Emergency: Name _____ Phone ( )_____

Relation to Patient:_____

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB_____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group #_____

Relation to patient _____

Secondary Dental Carrier (United Concordia, Cigna PPO, MetLife, United Concordia, Delta Premiere, Delta Dental of AZ, Only)

Subscriber Name_____ Social Security# _____DOB_____

Employer _____ Insurance Co. _____

Insurance Co. Phone # Group #

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

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 and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature_____ **Date**_____

Section A:

Fill out this *section* only if Patient is under 18 otherwise proceed to section B below.

Responsible Party_____ Relation to Patient_____

Address_____
(Street)

_____
(City) (State) (Zip)

Your Drivers License Number:_____ State: _____

Telephone Home ( ) _____ Cell ( ) _____

SECTION B:

How did you hear about us? _____ If person, please list their name.

What was the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

Have your teeth ever embarrassed you in the last year? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like *most* about your last dentist? _____

What did you like *least* about your last dentist? _____

Medical History and Information:

Do you have or have you ever had: **Yes** or **No**

- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Osteoporosis
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Diseases
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other

On a scale of 1-10 with 10 being perfect and 1 being very bad how would you rate the following:

Your teeth: _____

Your Gums: _____

Are you allergic to any of these items? (please circle) Yes or No

- ❑ Aspirin
- ❑ Barbiturate
- ❑ Codeine
- ❑ Latex
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other_____

Are you currently under the care of a physician?

Yes ❑ or No ❑ If yes please explain:

Please list any medication you are currently taking (including bone density medications, Baby Aspirin, or blood thinners):

Female Patients: Are you pregnant?
Yes ❑ or No ❑

If yes, when is your due date?

Would you be interested in treatment today if possible? Yes ❑ or No ❑

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____
PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Today's Dental Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve. Our goal is for you to enjoy a healthy, beautiful smile with respect to your budget. Fees for services provided by our office are based on a relative value scale which takes into account the education, time and skill required to perform each procedure. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment.

Optional Payment Terms:

1. Full Pay **Cash** Discount: We offer a **10%** accounting courtesy for all treatment paid in full by **CASH ONLY** at the time of service. If you have insurance we will still file your insurance and payment will go directly to you the patient.
2. Full Pay (day of service) **Cash** Discount: We offer a **5%** accounting courtesy for co-payments paid in full at the time of service- **CASH ONLY**.
3. Pre payment option: You may pay **in advance** for treatments listed on your treatment plan. We will credit your account for the services you need. Once full payment for that service is met, we will schedule and complete the needed treatment. **This will allow you to pay for the treatment a little at a time**.
4. Credit Card Payment Option: We allow (with a signed agreement form), a Credit Card Payment option, this allows you to make three equal installments by credit card. One-third payment is due at the first appointment, one-third is due thirty days later, and the remaining one-third is due sixty days from the initial appointment. Our office personnel will charge these payments to your credit card on the due dates.
5. Term Loan: By arrangement with **Care Credit**, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

Payments are expected at the time services are rendered. We accept cash, checks, ATM/debit cards, care credit and all major credit cards. There will be a $25 service charge on all returned checks.

Broken appointments: This time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, **we require at least 24 BUSINESS hours notice to avoid a $50.00 cancellation fee** (emergencies are an exception).

124 Timber Drive
Dayton, TN 37321
423-775-9971

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 March 23 2005, 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. 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 using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and 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 and 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 professionals, 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. Please list up to 3 people, and their relationship to you, whom you consent for us to talk to regarding your healthcare or payment information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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 health 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, counterintelligence, 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, text messages 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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.

Restrictions: 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 an 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 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. 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: Jalena Howard
Telephone: 423-775-9971
Fax: 423-570-9228
E-Mail: smile@todaysdentaldayton.com
Address: 124 Timber Drive
Dayton, TN 37321

I have read and understand my rights as they pertain to this notice.

_____ _____

Signature Date

Vital Information About Your Dental Insurance

Our office is happy to help file your insurance for you. We want you to receive the dental benefits paid for by you and your employer. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. **In other words, your insurance plan will pay only what it allows for each service, regardless of what our actual fee might be**. Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law. **Both our office and you, as the policy beneficiary, can be prosecuted if deductibles and co-payments are not collected.** Your Employee Benefits Director can usually help you become familiar with your plan and its' restrictions, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

Your responsibilities:

1. To pay the estimated fees not covered by your plan at the time of treatment.
2. To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
4. To pay any account balance not paid by insurance after 2 billing attempts.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We will add a 1.5% finance charge to over due accounts. To avoid this charge, please pay your account in full by the due date on your statement. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.

Waiver of confidentiality: You understand if this account is submitted to a collection agency or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office my become a matter of public record.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign this form below.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

_____ _____

HIPAA AUTHORIZATION FOR COMMUNICATIONS USING RHINOGRAM

Patient Name _____Date of Birth _____

1. I authorize the access, use, and/or disclosure of my information by Today's Dental (including its providers and clinical and administrative staff members) (the "Practice") in relation to our patient/provider relationship, as described below.
2. The type and amount of information to be accessed, used and/or disclosed is as follows: (1) communications between myself and the Practice for treatment, payment and/or health care operations via Rhinogram's communications platform across digital, social media, texting, and/or other communication channels (the "Platform"); and (2) transmissions of my patient information for treatment purposes only sent and/or received between the Practice and my other treatment providers (or other providers to whom the Practice refers me) via the Platform.
3. I understand that I have the right to revoke this Authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
4. Unless revoked earlier, this Authorization will expire on the following specified date, event or condition: expiration or termination of my patient/provider relationship with the Practice.
5. I understand that once information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and may not be protected by federal privacy regulations.
6. I understand that the Practice may not condition, prohibit, or prevent my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
7. I understand that I will be given a copy of, or access to, this Authorization form after it is signed.

Signature of Patient or Personal Representative: _____