American Dental Wellness **CONFIDENTIAL**

We go the extra mile for your smile!

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out the following forms completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help!

Patient Registration Information

Patient Information:

Name: ____ Preferred Name: __________________________

Last First Initial

Gender: ☐ Male ☐ Female

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Date of Birth: _______/_______/___________ Social Security Number: _______-_____-__________

Driver's License Number: ____

Home Phone: _________________________ Cell Phone: _________________________

Email: ____

Preferred Contact Method: Phone - ☐Home ☐Cell ☐Work ☐Email ☐Text Message

Who is responsible for this account? _____________________________ Relationship: _____________________

Home Address: Billing Address: ☐ Same as Home

____ ____

____ ____

Work Information:

Employer: ________________________________

Occupation: _______________________________

Work Phone: ______________________________

Other family members in our practice?

____

____

Spouse/Parent Information:

Name: _____________________________________

Gender: ☐ Male ☐ Female

Date of Birth: _________________________

Social Security Number: _______-_____-________

Employer: __________________________________

Occupation: ________________________________

Insurance Information:

Do you have dental insurance? ☐ Yes ☐ No

Dental Insurance Company: ___________________________________ Ins. Phone #: (______) _______________

Name of Insured: _____________________________________ Subscriber ID: ____________________________

Subscriber DOB: _________/_________/__________ Employer: ____

Emergency Contact:

Please Continue ➲

Full Name: ____ Relation: ____________________________

Contact Phone Number: (_________) ______________________________

Additional Insurance:

Do you have any additional dental insurance? ☐ Yes ☐ No
If yes, please complete the following:
Name of Insured: ____ Relationship: ____________________________

Dental Insurance Company: ______________________________________ Ins. Phone #: (______) _______________

Subscriber ID: _____________________________ Group Number: ___________________________________

Subscriber DOB: _________/_________/__________ Employer: ____

Authorization, Release, and Agreement to Pay for Services Rendered:

I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent(s).

X____ ____________________________

Signature of Patient or Parent/Guardian if Minor Date

Financial Arrangements:

For your convenience, we offer the following methods of payment:

Please check the option with which you prefer to pay your deductible, co-payment, and/or non-covered benefits today.

☐ Cash ☐ Personal Check ☐ Credit Card (Visa/MC/AMEX/Discover) ☐ Care Credit ☐ Chase Health Advance

Ask us about our financing options available to you!

How did you hear about our office? ☐ PPO Insurance Provider List ☐ Yellow Pages – AT&T Book

☐ YP.com ☐ Google ☐ Bing ☐ Yahoo ☐ ZipLocal/Your Community Book

☐ YellowBook ☐ MINT Magazine ☐ MONEY Pages ☐ Street Signs

☐ Hospital/Doctor's Office: ______________________________ ☐ Referring Patient: ____________________________

☐ Referring Dentist: _____________________________________ ☐ Other: ____________________________________

*****Referral Program: If you are a patient in our office & refer 3 other new patients who participate in our dental services, you will receive a special "Thank You" bonus.*****

Prescription Drug Policy:

Due to the nature of our practice, please be advised that American Dental Wellness 1) Does not provide narcotics for chronic pain management. 2) Does not dispense OXYCODONE or any other Class 2 drug. 3) Does not authorize refills for antibiotics without a follow-up visit for reevaluation of your dental condition.
5) Is not responsible for lost or stolen prescriptions.

Guarantor/Patient Agreement:

I hereby agree to the following: (i) I am responsible for the charges of all services the "Patient" receives for, or related to, or connected with this visit(s), and same are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are readily available from any American Dental Wellness staff member and I am fully aware payment is due at the time dental services are provided. (ii) If American Dental Wellness bills third party payers*, they do so as a courtesy, and American Dental Wellness may demand payment in full of any balance due, at any time. (iii) I understand that American Dental Wellness may bill me separately. (iv) If I am more than thirty **(30) days** overdue in the payment of any bill, **a finance charge** will accrue on the unpaid balance every month until paid in full.** (v) If I am more than ninety (90) days overdue on the payment of the final bill, I may be declared in default, and the overdue account may be referred to a collection agency, in which case I agree to pay attorney's fee, court costs, and/or collection agency fees associated with the collection process.

Please Continue ➲

Insurance Verification Policy:

Our staff will do everything possible to verify your insurance benefits and eligibility. If treatment is provided AFTER HOURS or on WEEKENDSAND WE ARE UNABLE TO VERIFY YOUR DENTAL INSURACE COVERAGE please be advised that due to the nature of our practice, payment for services is expected at the time of service. We accept Cash, Checks (must be imprinted with name and address, and will be electronically scanned), Debit Cards, MasterCard, Visa, and Discover. American Dental Wellness accepts most insurance plans and will be happy to file your insurance provided tah eligibility, deductible, and co-payment amounts can be verified prior to the rendering of services. Otherwise, PAYMENT IN FULL WILL BE EXPECTED AT THE TIME SERVICE IS RENDERED. For your convenience, American Dental Wellness can either submit the claim on your behalf to your insurance company or applied toward your annual deductible, whichever is applicable.

****Late Charges:**

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and additional attorney fees incurred in attempting to collect on this amount or any further outstanding account balances.

*Third party payers include, but are not limited to, coverage available from Tri-Care or governmental programs; dental, accident, automobile, or other insurance; workers compensation; PPO (commercial); self-insured employers; and any sponsors who may contribute payment for services.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions or concerns at any time, please ask us. We are always happy to assist you.

Please Continue ➲

Patient Dental History

Patient's Name: ______________________________ **Date of Birth**: ____/____/_______

REASON FOR THIS VISIT: ______________________________

DO YOU WANT US TO LIMIT YOUR TREATMENT TO THIS CHIEF COMPLAINT? ☐ YES ☐ NO

WHEN WAS YOUR LAST DENTAL VISIT? ____________ WHAT WAS DONE THEN? ____________

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN? ______________________________

PREVIOUS DENTIST (NAME & LOCATION): ______________________________

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN? ☐ YES ☐ NO ☐ NOT SURE

IF SO, WHEN/WHERE? ______________________________

HOW OFTEN DO YOU BRUSH YOUR TEETH? ____________ HOW OFTEN DO YOU FLOSS YOUR TEETH? ____________

IS YOUR DRINKING WATER FLUORIDATED? ☐ YES ☐ NO ☐ NOT SURE

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
HAVE YOU HAD ANY HEAD/NECK/JAW INJURIES?	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW:		
CLICKING	☐	☐
PAIN (JOINT/EAR/SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES?	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
DO YOU BITE YOUR LIPS OR CHEEKS OFTEN?	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?	☐	☐
HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE?	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
DO YOU WEAR DENTURES OR PARTIALS?	☐	☐
IF YES, DATE OF PLACEMENT: ____________		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? ______________________________

____

AUTHORIZATION & RELEASE:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTYPAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

DOCTOR'S COMMENTS: ______________________________

____

____________ **SIGNATURE:** ____________ **DATE:** ____________

Please Continue ➥

American Dental Wellness, P.A.

Patient Medical History

Patient's Name: ____ **Date of Birth**: ____/____/_______

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

AUTHORIZATION & RELEASE: PATIENT SIGNATURE:___________________________ DATE:___________________

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTYPAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

	YES	NO
ARE YOU IN GOOD HEALTH?	☐	☐
HAVE HERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	☐	☐

DATE OF YOUR LAST PHYSICAL EXAM: ________________

PHYSICIAN'S NAME: ______________________________

ADDRESS: ____________________________________

PHONE NUMBER: ____________________________

	YES	NO
ARE YOU UNDER THE CARE OF A PHYSICIAN?	☐	☐
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐

PLEASE EXPLAIN: _______________________________

____

	YES	NO
ARE YOU TAKING ANY MEDICINE(S), INCLUDING NON-PRESCRIPTION MEDICATION(S)?	☐	☐

PLEASE LIST: __________________________________

____

	YES	NO
HAVE YOU HAD ANY ABNORMAL BLEEDING?	☐	☐
DO YOU BRUISE EASILY?	☐	☐

	YES	NO
HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
HAVE YOU HAD RECENT WEIGHT LOSS?	☐	☐
HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
DO YOU USE TOBACCO?	☐	☐
DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?	☐	☐
ARE YOU WEARING CONTACT LENSES?	☐	☐
DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
DO YOU HAVE A DISEASE, CONDITION, OR PROBLEM NOT LISTED YOU THINK I SHOULD KNOW ABOUT?	☐	☐

WOMEN ONLY:

	YES	NO
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

Please Continue ➲

Patient Medical History

Continued from the previous page

	YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:		
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES, OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX/RUBBER	☐	☐
OTHER (PLEASE LIST) ______________________________		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE/HEART ATTACK/ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, HANDS, ANKLES	☐	☐
HEPATITIS, JAUNDICE, OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG/BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐

Do you take blood thinner Yes or No

	YES	NO
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐

Do you take Aspirin Yes or No

Have you ever taken medication for **the treatment of OSTEOPOROSIS**, either orally or through IV route? ___Y or ___No

If yes, what medication and what dosage?____

	YES	NO
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

SIGNATURE OF PATIENT OR GUARDIAN OF A MINOR: ______________________________________

DATE: ________________

DOCTOR'S COMMENTS: ____

____

______________________________________ **SIGNATURE:** ______________________________ **DATE:** ______________

Please Continue ➲

American Dental Wellness

38A Blanding Blvd
Orange Park, FL 32073
Phone: 904-272-9440
www.AmericanDentalWellness.com

MISSED/CANCELED APPOINTMENT POLICY

To Our Valued Patients:

If you find you are unable to keep a scheduled appointment, we would appreciate it if you could kindly give us notice. While we understand the fact that sometimes unavoidable situations may occasionally arise, we reserve the right to assess the following missed appointment charges:

- 1 Hour Appointment: $25 (without 24 hour notice)
- 2 Hour Appointment: $50 (without 48 hour notice)
- 2 ½ Hours or More Appointment: $100 (without 72 hour notice)

Thank you for your cooperation and understanding,

American Dental Wellness, P.A.

____

Patient Signature Date

____

Parent/Guardian Signature Date

TREATMENT PLAN POLICY

Treatment plans are an estimate valid for 90 days from the date entered. If during the course of treatment it becomes imperative to alter plans, you will be informed of any necessary changes. The estimate of benefits is not a guarantee of payment by insurance. Benefits are affected by eligibility at the time of service, policy provisions and limitations, and benefits that may have been paid to another office. The estimate of benefits is based on information that your insurance carrier provided to our office. We do all we can to correctly estimate your out-of-pocket expenses, but please be aware that you as the policy holder are responsible to know the coverage provided by your policy. You are ultimately responsible for all charges.

Signature Date

____

Please Continue ➲

American Dental Wellness, P.A.

INFORMED CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless/until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking, antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure, or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations, or gums.
5. Possible deterioration of your condition, which may result in tooth loss.
6. The need for replacement of restorations, implants, or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication.
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Signature ____________________ Date ____________ Witness Signature ________________________ Date _______

______________________________ Print Patient Name

________________________ Parent/Legal Guardian _______ Date

Please Continue ➲

American Dental Wellness

PAYMENT POLICY FOR ALL MAJOR PROCEDURES/APPOINTMENT RESERVATIONS

To reserve an appointment for any and all major procedures, or procedures exceeding $500.00 in value, American Dental Wellness requires a deposit of $150.00. The deposit must be made a minimum of 48 hours prior to appointment date. This amount will be applied towards total out of pocket expense for patient procedures performed on that day of service.

If you need to cancel or re-schedule the appointment, we require a 48 hour notification of the cancellation or request for re-scheduling of appointment to another day. If we are not notified 48 hours prior you will be charged a fee according to the guidelines stipulated in the new patient paperwork. If applicable this amount will be deducted from the deposit made to reserve appointment.

I have read and understand the above policy of AMERICAN DENTAL WELLNESS, P.A.

____ __________________________

Patient Signature Date

Please Continue ➲

American Dental Wellness, P.A.

We go the extra mile for your smile!

ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I have received a copy of the Joint Notice of Privacy Practices American Dental Wellness, P.A.,

____

Please Print Name

____

Signature

____

Date

**You may refuse to sign this acknowledgement.

For Office Use Only

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

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining the acknowledgement.

☐ Other (please specify): ______________________________________

____

____

____

Please Continue ➲

American Dental Wellness, P.A.

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) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in form, whether electronically, on paper, or orally, be kept properly confidential. This act gives you, the patient, significant 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.

We may use and disclose your medical records only for each of the following purposes:

- **Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include referring to a specialist.
- **Payment:** obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilizing review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations:** the business aspects of running our practice, such as conducting quality assessment and improvement activities, including functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

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.

Please Continue ➲