Acknowledgement of Receipt of Joint Notice of Privacy Practices

I acknowledge that I have read Addison Dental's Joint Notice of Privacy Practice and that I have had any questions regarding the notice answered to my satisfaction.

Patient/Guardian Print Name: _____

Patient/Guardian Signature: _____

Relationship to Patient (if someone other than patient): _____

Date: _____

ADDISON DENTAL
FINANCIAL AGREEMENT

It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatment affordable to all our patients. Please review the following office policies and procedures:

PAYMENT POLICY: Payment is due at the time services are rendered. If we are an in-network provider under your dental insurance, your estimated co-pay plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.

- We accept cash, personal checks with proper ID, debit cards, visa, MasterCard, Discover and American Express.
- We offer an in-house dental savings plan (Quality Dental Plan) for added savings.
- We offer long-term, interest-free financing through CareCredit (requires approval).
- A 1.5 % monthly finance charge (18% annually) will be applied to all outstanding accounts beginning at 90 days.
- You will be responsible for any and all costs incurred in the collection of your debt (i.e., collection agency fees, court fees, and/or attorneys' fees).
- Fees will apply for any checks that is returned by the bank.

DENTAL INSURANCE: We will file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and/or all of the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
- **Although we may estimate your insurance benefits, we are not responsible for their accuracy.** Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. **Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.**
- Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. In such cases, we may not be able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company and notify us if this is the case.
- **All charges not paid by your insurance company are your responsibility regardless of the reason for non-payment.** Not all services we provide are covered benefits. Benefits differ from one company to another. **Fees for non-covered services, along with deductibles and copayments are due the time services are rendered.**
- We are an amalgam-free office and only place composite (tooth-colored) fillings. It is likely that your insurance company will only cover amalgam (silver) fillings. You are responsible for the cost difference between the composite and the amalgam fillings.

- There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. WE will provide you with the most accurate information available to us, but we **CANNOT** guarantee what your out of pocket expense will be.
- Please understand that our responsibility is always to provide you with the highest quality care for your specific dental needs, not to try and match your care to fit your insurance plan limitations, but we will work with you to help make your dental care as affordable as possible.
- **We will bill you for any balance left after your insurance company pays us and all applicable write-offs have been taken.**

BROKEN OR MISSED APPOINTMENTS: To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of $50.00 per hour scheduled. At our office, we are able to offer only the highest quality dentistry because we only book **one** patient at a time. Because we do not double book appointments, it is crucial that we have at least 24 hours notice to be able to fill any open appointment slots.

- We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

I have read and understand this document outlining the office and financial policies of Addison Dental and agree to these terms. I give permission for any information regarding my dental care to be released to my insurance company for payment consideration.

Signature of patient or parent/guardian:

_____

Date: _____

TIME 12:53 PM

DATE 9/15/2015

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Date: _____/_____/_____

MEDICAL HISTORY FORM

Name: _____

DOB: _____/_____/_____

For the following questions, please check the appropriate box. Your answers are for our records only and are considered confidential.

1. Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Has there been any change in your health since last year? ☐ Yes ☐ No
   If yes, explain: _____

3. Date of last physical exam: _____/_____/_____

4. Primary Care Physician's Name: _____
   Address:_____
   Phone: _____

5. Are you taking any medicine (s) or vitamin supplement(s), including non-prescription? ☐ Yes ☐ No
   If yes, please list the names and dosages:
   _____ _____
   _____ _____
   _____ _____
   _____ _____

6. Have you had an allergic reaction or serious side effect to any medication? ☐ Yes ☐ No
   If yes, please specify: _____

7. Do you take or have you **EVER** taken Phen-Fen or Redux? ☐ Yes ☐ No
   If yes, what date(s): _____

8. Do you take or have you **EVER** taken Fosamax, Boniva, Actonel or any other medications (oral or intravenously) containing bisphosphonates? ☐ Yes ☐ No
   If yes, what date(s): _____

9. Have you had any serious illness, hospitalization, or operation within the last 5 years? ☐ Yes ☐ No
   If yes, please explain: _____

8. Have you ever had a serious head or neck injury? ☐ Yes ☐ No
   If yes, please explain: _____

9. Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____

10. Do you use controlled substances/drugs? ☐ Yes ☐ No If yes, describe: _____

11. Are you allergic to **ANY** of the following?

☐ Aspirin ☐ Latex ☐ Codeine ☐ Penicillin ☐ Metal ☐ Sulfa Drugs ☐ Acrylic
☐ Local Anesthetics ☐ Other: _____

Do you now or have you ever had a history of:

Neurological Disorders:
☐ Stroke or Mini Stroke (T.I.A.)
If yes, date(s): _____
☐ Seizures
☐ Back/Neck Problems
☐ Forgetfulness/Memory Loss/Confusion
☐Alzheimer's Disease
If yes, date diagnosed: _____
☐ Dementia
If yes, date diagnosed: _____
☐ Multiple Sclerosis/Muscular Dystrophy
☐ Nerve/Spinal Cord Injury
☐ Neuropathy
☐ Spina Bifida
☐ Frequent Headaches
☐ Other
Please describe: _____

Blood Disorders:
☐ Anemia
☐AIDS/HIV Positive
☐ Blood Transfusion
If yes, date: _____
☐ Hemophilia
☐ Excessive Bleeding
☐ Sickle Cell Disease
☐ Leukemia
☐ Other Blood Disease
If yes, please describe: _____

Other Disorders:
☐ Cold Sores/Fever Blisters ☐ Genital Herpes
☐ Herpes ☐ Osteoporosis
☐ Scarlet Fever/Rheumatic Fever ☐ Shingles
☐ Venereal Disease ☐ Tonsillitis

Cardiovascular Disease:
☐ Heart Attack
If yes, date(s): _____
☐ Irregular Heartbeat
☐ Pacemaker/Defibrillator
If yes, brand: _____
☐ Circulation Problem(s)
☐ Blood Clot in Legs or Lungs
☐ High Blood Pressure
☐ Low Blood Pressure
☐ High Cholesterol
☐ Damaged/Artificial Heart Valves
☐ Rheumatic Heart Disease
☐ Angina
☐ Arteriosclerosis
☐ Chest pain/Tightness/Pressure
☐ Chest pain on exertion
☐ Shortness of breath after mild exercise
☐ Ankles Frequently Swell
☐ Fainting Spells/Dizziness
☐ Bruise Easily
☐ Congenital Heart Disorder
☐ Mitral Valve Prolapse

If you are a woman:
Could you be pregnant? ☐ Yes ☐ No

Endocrine Disorders:
☐ Diabetes
If yes, what type? _____
If yes: ☐ Insulin Injections ☐ Insulin Pump
☐ Hypoglycemia
☐ Thyroid Disease
If yes, describe: _____
If yes, date of diagnosis: _____
☐ Parathyroid Disease
☐ Excessive Thirst
☐ Rheumatoid Arthritis
☐ Arthritis
☐ Gout

Kidney/Bladder/Prostate Disorders
☐ Kidney Disorder
If yes, describe: _____
☐ Bladder Disorder
If yes, describe: _____
☐ Prostate Disorder
If yes, describe: _____
☐ Dialysis
If yes, schedule: _____

Psychiatric Disorders
☐ Anxiety or Nervousness

Taking oral contraceptives? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
Problems With Menstrual Period? ☐ Yes ☐ No
Hormone Replacement Therapy? ☐ Yes ☐ No

☐ Anorexia
☐ Bulemia
☐ Other Mental Health Issue
Please describe: _____ _____

Respiratory Disease:

☐ Smoking/Tobacco
If yes, amount per day: _____
If quit, list date: _____
☐ Asthma
☐ Emphysema/Bronchitis
☐ Shortness of Breath at Rest
☐ Sleep Apnea
If yes, use CPAP? ☐ Yes ☐ No
If yes, use oral appliance? ☐ Yes ☐ No
☐ Snoring
☐ Allergies/Hay Fever
☐ Tuberculosis
If yes, date diagnosed: _____
☐ Persistent Cough
☐ Cough that Produces Blood
☐ Sinus Trouble

Gastrointestinal/Liver Disease:

☐ Hepatitis A
If yes, date of diagnosis: _____
☐ Hepatitis B
If yes, date of diagnosis: _____
☐ Hepatitis C
If yes, date of diagnosis: _____
☐ Jaundice
☐ Liver Disease
If yes, describe: _____
☐ Stomach Ulcer
☐ Esophageal Reflux
☐ Hiatal Hernia
☐ Frequent Diarrhea
☐ Other Gastrointestinal Disease
If yes, please describe: _____
If yes, date diagnosed: _____

Cancer/Lymphatic Disorders:

☐ Cancer

If yes, please describe: _____

_____

If yes, date of diagnosis: _____

_____

☐ Tumors/Growths

If yes, please describe: _____

_____

☐ Chemotherapy

☐ Radiation Therapy

☐ Recent Weight Loss

☐ Swollen Glands

☐ Night Sweats

Physical/Oral Symptoms:

☐ Hives/Rash

☐ Pain in Jaw Joints

☐ Frequent Canker Sores

☐ Pain in Mouth

☐ Dry Mouth

☐ Grinding/Clenching

☐ Use Removable Dental Appliance

Visual/Hearing Disorders:

☐ Contact Lenses

☐ Glaucoma

☐ Retinal Detachment

☐ Hearing Loss

☐Other: _____

12. Do you have an artificial joint? ☐ Yes ☐ No Explain: _____

13. Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please explain: _____

14. Have you ever had any serious problem associated with a previous dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the doctor, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Guardian: _____ Date: _____

MEDICAL HISTORY UPDATES:

DATE:	**COMMENTS:**	**SIGNATURE:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by 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 September 21, 2012, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may 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. We will post a copy of our notice in our office and on our website www.addison-dental.com. The effective date of the Notice is provided above.

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 the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may 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 another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

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, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: s explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. 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 uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: 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, and healthcare operations, and certain other activities for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 9700 S. Dixie Highway, Suite 910, Miami, FL 33156.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 9700 S. Dixie Highway, Suite 910, Miami, FL 33156. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be

contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 9700 S. Dixie Highway, Suite 910, Miami, FL 33156.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to Privacy Officer, 9700 S. Dixie Highway, Suite 910, Miami, FL 33156. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, 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, 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 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.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
9700 S. Dixie Highway, Suite 910
Miami, FL 33156
Telephone: (305) 670-9755

Patient Photo Release Form

I _____, hereby authorize Dr. John Addison, DMD, (Addison Dental) or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please INITIAL below:

_____I do not mind if my photographs are used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

Signed_____Date_____