

Welcome

Patient ID # _____ Today's Date _____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
SS# / SIN _____
School _____ Grade _____
Child's Home Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Phone _____

Responsible Party

Name _____
Relationship _____
Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Email _____
Phone _____ SS#/SIN _____
DL# _____

Who is responsible for making appointments?

Name _____ Best time to call _____
Home Phone _____ Cell Phone _____ Time _____ Day _____
Work Phone _____ Ext. _____

Mother

Stepmother Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS#/SIN _____
DL # _____

Father

Stepfather Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS#/SIN _____
DL # _____

Marital Status Single Married Divorced
 Widowed Separated

Marital Status Single Married Divorced
 Widowed Separated

Primary Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/Prov. _____ Zip/P.C. _____
Deductible _____ Copay _____
Amount already used _____
Max. annual benefit _____

Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/Prov. _____ Zip/P.C. _____
Deductible _____ Copay _____
Amount already used _____
Max. annual benefit _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. Cash Personal Check
 Credit Card Visa MC I wish to discuss the office's payment policy.
 Discover AMEX

Dental & Health History

CONFIDENTIAL

Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated?..... Yes No Does your child take fluoride supplements?..... Yes No

Does your child:

Suck thumb/finger..... Yes No Chew hard objects (pencils, etc.)..... Yes No

Suck/Bite lip..... Yes No Grind teeth..... Yes No

Bite/Chew nails..... Yes No Clench jaws..... Yes No

Previous dentist _____ Address _____

Date of last dental visit? _____

Has your child had difficulty with previous dental visits? Yes No

Child's physician _____ Address _____

Phone # _____

Previous Hospitalizations/Surgeries/Serious Illnesses? _____ When? _____

Is your child currently taking medications? Yes No (if yes, please list) _____

Has your child ever taken FenPhen/Redux? Yes No _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? Yes No (if yes please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? Yes No _____

Has your child ever had any of the following:

Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach, liver or kidney problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicaps/Disabilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Defect..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Acid Reflux..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions/Epilepsy..... <input type="checkbox"/> Yes <input type="checkbox"/> No
	Osteoporosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any medical problem that your child has: _____

Authorization & Release

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my 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 _____

Dentist Review _____

Signature of Dentist _____ Date _____

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:

Patient's Date of Birth:

Patient's SSN:

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Patient's Signature or Signature of Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Barbara Wilson

Practice Address: 9235 North Union Boulevard #170
Colorado Springs, CO 80920

Phone: (719)494-2865

Fax: (719)282-6091

E-Mail:
office@corderadental.com

HIPPA Consent for Use / Disclosure of Health Information

This form does not constitute legal advice and covers only federal, not state, laws.

**Cordera Family Dentistry
Hans Egbert D.D.S.
Policy Form**

Office Financial Policies

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. Estimates given through our office are NOT a guarantee of payment by your insurance company. **Your portion of the bill will be due at time of service.**

If your insurance has not paid within 60 days from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account including, but not limited to, interest, rebilling fees, court costs, attorney fees, and collection agency costs will be passed on to the patient and/or the responsible party.

Any returned checks will be charged a \$40.00 returned check fee. Broken appointments without 24 hour notice are assessed a \$25.00 broken appointment fee. All fees are due before any further services are rendered. Any account that has gone past due will be required to pre-pay for further services.

I understand that intentionally providing false information in attempt to receive undue insurance benefits constitutes fraud and will be prosecuted as such.

Signature

Date

Insurance Regulations and Assignment of Benefits

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health care information to carry out payment activities in connection with claims submitted from this office. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Cordera Family Dentistry.

Signature

Date

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on Dec 1, 2010 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Barbara Wilson. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

(a) Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$ 2 for each page and the staff time charged will be \$ 20 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

(b) Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where "the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$ 2 for each page and the staff time charged will be \$ 20 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Practice Name: <u>Cordera Family Dentistry</u>	Privacy Officer: <u>Barbara Wilson</u>
Telephone: <u>(719) 494-2865</u>	Fax: <u>(719) 282-6091</u>
Address: <u>9235 N. Union Blvd, Unit 170, Colorado Springs, CO 80920</u>	
Email: <u>office@corderadental.com</u>	