

I have received a copy of the Notice of Privacy Practices for Protected Health Information.

Signature

Date

Evans Family Dentistry

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This information describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes:

The doctor obtains your treatment information and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of uses of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding dental care given. We will provide information to them about you and the care given.

Example of uses if your information for health care operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- * Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request; but we will comply with any request granted;
- * Ask someone who has medical power of attorney or your legal guardian, to exercise your rights and make choices about your health information
- * Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full - we must comply with this request;
- * Obtain a copy of your paper or electronic record
- * Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- * Request that you be allowed to inspect and copy your health record and billing record. You may exercise this right by delivering the request in writing to our office;
- * Appeal a denial of access to your protected health information except in certain circumstances;
- * Request that your healthcare record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- * File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- * Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- * Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- * Revoke authorization that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Misti Hombree, 7141 Clinton Hwy, Suite A, Powell, TN 37849, in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and healthcare operations purposes.

Our Responsibilities

The practice is required to:

- * Maintain the privacy of your health information as required by law;
- * Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- * Abide by the terms of this Notice;
- * Notify you if we cannot accommodate a requested restriction or request; and
- * Accommodate your reasonable requests regarding methods to communicate health information with you.
- * We will never share your information (for marketing purposes, sale of your information, sharing of psychotherapy notes) without your written permission; and
- * Notify you if you are affected by a breach of unsecured PHI

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our Notice or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Misti Hombree, 7141 Clinton Hwy, Suite A, Powell, TN 37849. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Misti Hombree. You may also file a complaint by mailing it to the Secretary of Health and Human Services whose street address is 200 Independence Ave., SW Washington, DC 20201

* We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.

* We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, or other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect

We may disclose your personal health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

For Specialized Governmental Functions

We may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Website

If we maintain a website that provides information about our entity, this notice will be on the website.

Financial Policy

Please read carefully and sign:

Basic Financial Policy: Payment in full for services rendered. We accept cash, debit cards, MasterCard, Visa, Discover, and Care Credit.

I fully understand and agree that I am responsible for the payment of this account. All accounts over 90 days are subject to a 2% monthly (annual percentage rate of 24%) service charge. I understand if this balance is not paid in full within a reasonable amount of time, (90 days or less); Evans Family Dentistry has the right to take legal action. In the event this account is involved in litigation I expressly waive any objection to venue. I understand I will be responsible for additional costs incurred should collections become necessary. I, the responsible party, agree to pay these costs which can include court and/or attorney fees PLUS an additional 40% for collection agency fees. I authorize Evans Family Dentistry's collection agency to obtain my credit report from any of the three major reporting agencies. If I have any questions or concerns or if I require other financial arrangements I will ask before treatment is rendered. When applying for credit, I authorize the release of any employment records to Evans Family Dentistry and authorize Evans Family Dentistry to access necessary credit information.

Minors: The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Care Credit, Visa, MasterCard, Discover, or payment by cash or check at the time of service.

Patients with Insurance: As a courtesy to our patients we do accept assignment of benefits and will bill your insurance carrier provided proper paperwork is provided. Patients without proper insurance identification will be considered private pay and will be responsible for their balance on the day of service. It is the patient's responsibility to provide us with correct billing information. Incorrect information may cause delays in the payment of your account. We will expect you to begin making "good faith" payments in the event your insurance processing goes over 90 days due to incorrect billing information given on the day of service. It is our policy to collect all co-pays and deductibles on the day of service. We do our best to determine what your insurance will pay but this is not always possible. You may owe an additional balance or we may owe you a refund.

Some benefit plans require pre-authorization. It is your responsibility to know your insurance requirements. It will be helpful for you to call your insurance company prior to your appointment day to determine if you need any prior authorization.

It is your responsibility to know if your dental plan has a maximum payout per year and to know

how much of this you have used for the year. (Some plans have a \$1000 max and some may have \$1500 - \$2000 max per year).

Workman's Compensation: We require the necessary insurance billing information and employer authorization.

Personal Injury Cases: This office does not accept liens nor bill auto accident, liability, or lawsuit related cases. The patient is responsible for payment at the time services are rendered.

Divorced Parents: We will be glad to bill the responsible parent for your child's account. However, both parents are responsible for a minor child's bill and both parents will be held accountable. We are not a party to your divorce decree. It will be up to the parents to determine "who owes what".

Insurance Waiver: I have been informed by Evans Family Dentistry that the services rendered on this date may be denied by my insurance carrier as services not covered by the plan provisions, including but not limited to denials due to plan maximums or limits. I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR ALL SERVICES RENDERED BY EVANS FAMILY DENTISTRY.

My signature certifies that I have read and understand the financial policy of Evans Family Dentistry. I authorize the release of any medical records or other information necessary to process my insurance claim(s). I authorize payment of benefits otherwise payable to me, directly to the provider of services listed on claim(s)/ Evans Family Dentistry.

SIGN NAME

DATE

PRINT NAME

Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle			Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: <i>Mailing address</i>			City:	State: Zip:
Occupation:	Height:	Weight:	Date of Birth:	Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: <i>Include area code</i> ()	Cell Phone: <i>Include area code</i> ()

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) **Yes No DK**

Active Tuberculosis

Persistent cough greater than a 3 week duration

Cough that produces blood

Been exposed to anyone with tuberculosis

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes No DK		Yes No DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam: _____	
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		What was done at that time?	
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays: _____	
What is the reason for your dental visit today?			
How do you feel about your smile?			

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes No DK		Yes No DK
Are you now under the care of a physician?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____	Phone: <i>Include area code</i> ()	If yes, what was the illness or problem?	
Address/City/State/Zip: _____		Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
Has there been any change in your general health within the past year?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
If yes, what condition is being treated?		_____	
Date of last physical exam: _____		_____	

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? **Yes No DK**

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax[®], Actonel[®], Atelvia, Boniva[®], Reclast, Prolia) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia[®], Zometa[®], XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date Treatment began: _____

Allergies. Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction. **Yes No DK**

Local anesthetics

Aspirin

Penicillin or other antibiotics

Barbiturates, sedatives, or sleeping pills

Sulfa drugs

Codeine or other narcotics

Do you use controlled substances (drugs)?

Do you use tobacco (smoking, snuff, chew, bidis)?

If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant?

Number of weeks: _____

Taking birth control pills or hormonal replacement?

Nursing?

Yes No DK

Metals _____

Latex (rubber) _____

Iodine _____

Hay fever/seasonal _____

Animals _____

Food _____

Other _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes No DK	Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes No DK	Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes No DK
Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)	Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you snore? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>	Cancer/Chemotherapy/Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Specify: _____
Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes No DK	Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G.E. Reflux/persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe headaches/migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: *Include area code* () _____

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____
