North Royalton Family Dental

6391 Royalton Road, Suite A | North Royalton | OH 44133 | P: (440) 457-1221 | F: (440) 457-1223 | contact@nrfdental.com

NEW PATIENT INFORMATION

(CONFIDENTIAL INFORMATION FOR OUR FILES)

Last name: ________________________ First name: ________________________ MI:________

Date of birth:__________________ SSN: ____________________ Driver's license number:______________________

Email address: ____

Home phone: ____________________ Cell: ______________________ Work Phone: ____________________

Address: ________________________________ City: ______________________ State:________ Zip:__________

Your employer: ____________________________ May we contact you at work? ....❍ Yes ❍ No

HOW DID YOU HEAR ABOUT NORTH ROYALTON FAMILY DENTAL? ❍ Drive by ❍ Internet ❍ Direct Mail ❍ Insurance Plan ❍ Friend/Family ❍ Other | Referring patient name:________________________________

Spouse's name: ____ Phone: ______________________

IN CASE OF EMERGENCY, CONTACT: ________________________________ Phone:____________________

Previous Dentist (name/address/phone):____

Do you have any current x-rays (within 1 year) at your previous office? ....❍ Yes ❍ No

If yes, may we contact them to request copies be sent to us?......❍ Yes ❍ No

Primary Insurance Information

Insurance company: ______________________________

Insurance company City and State:______________________

Name of insured: ________________________________

Group name/number:______________________________

Insured date of birth: ____________ SSN:______________

Insured/Subscriber ID: ____________________________

Employer:______________________________________

Secondary Insurance Information (if applicable)

Insurance company: ______________________________

Insurance company City and State: ______________________

Name of insured: ________________________________

Group name/number:______________________________

Insured date of birth: ____________ SSN:______________

Insured/Subscriber ID: ____________________________

COMMENTS: ____________________________________

I authorize my insurance benefits to be paid to North Royalton Family Dental. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that ultimately I am financially responsible for all services I receive including co-pays, deductibles and non-covered services. Payment is expected at the time of treatment unless other arrangements have been made. I understand that my account can be assessed a monthly finance charge if my balance is carried longer than 30 days. I understand there will be a $35 fee for checks with insufficient funds. If I fail to show for an appointment or do not provide 48 hours advance notice before rescheduling, I may be assessed a $25 fee or up to the value of the appointment.

Patient, Parent or Guardian Signature: ______________________________ Date:______________

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INSURANCE PLANS AND FINANCIAL OPTIONS

(CONFIDENTIAL INFORMATION FOR OUR FILES)

Thank you for choosing North Royalton Family Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our goal is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS & INSURANCE PLANS WE ACCEPT

We accept Cash, Check, Visa, Mastercard, Discover Card or American Express

Dental treatment should fit into your budget without you having to sacrifice the quality of dental care.

Or, you may choose NO INTEREST[1] Payment Plans[2] from CareCredit

Allows you to pay over time with NO INTEREST[1] | Convenient, low monthly payment plans[2] also available
No annual fees or pre-payment penalties | Pays for deductibles and treatments not covered by insurance

We are in-network with most dental insurance plans.

Careington | Cigna PPO | Delta Dental DPO | Humana | Metlife
Maverest | Dental Health Alliance | Principal | Superior Dental Care
We are continuously updating the insurance plans we accept. If you don’t see your plan listed, please ask if we accept it.

Please note:

• For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. However, you are ultimately responsible for all charges and anything insurance does not cover.[3]

• We reserve the right to charge a fee of $25, or up to the value of the appointment, for patients who miss or cancel without 48 hours notice.

• North Royalton Family Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

• North Royalton Family Dental charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient Name (Please Print): ____

Patient, Parent or Guardian Signature: ______________________ Date:____________

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2]Subject to credit approval.
[3]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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PATIENT MEDICAL HISTORY

(CONFIDENTIAL INFORMATION FOR OUR FILES)

Patient's name: ____ Date of birth:____________________

Are you currently under a physician's care?..............................❍ Yes ❍ No
If yes, please explain: ____

Physician's name:____________________________________ Physician's phone:______________________

Are you taking any medications, pills, drugs, or supplements? ❍ Yes ❍ No If yes, please list name and dosage: ______________

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Do you take aspirin daily?...❍ Yes ❍ No Quantity? _________ How often? _________
Have you been hospitalized in the past five years?.............❍ Yes ❍ No If yes, for? _________________________
Do you have a prosthesis (i.e. a knee or hip replacement)? ❍ Yes ❍ No
If yes, specify type and date of your prosthesis ____
Does your physician require you to take an antibiotic prior to any dental treatment? ❍ Yes ❍ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?
❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics ❍ Other (please explain):_______________________

FOR WOMEN ONLY Are you pregnant?.............................❍ Yes ❍ No ❍ If yes, what is your due date?____________________

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Is there anything you would like to change about your smile?
❍ Whiter ❍ Straighter ❍ Close Space ❍ Replace silver amalgam fillings ❍ Less gums showing
❍ Repair chipped teeth ❍ Replace Missing Teeth ❍ Replace old crowns ❍ Other: ___________________________

Do you have a history of any of the following? Please check Yes or No.

Condition	Yes / No
A.I.D.S.	❍ Yes ❍ No
Anemia	❍ Yes ❍ No
Arthritis	❍ Yes ❍ No
Artificial Heart Valve	❍ Yes ❍ No
Asthma	❍ Yes ❍ No
Blood Disease	❍ Yes ❍ No
Cancer	❍ Yes ❍ No
Cholesterol	❍ Yes ❍ No
Diabetes (if yes, Type 1 / Type 2)	❍ Yes ❍ No
Ear Problems	❍ Yes ❍ No
Epilepsy	❍ Yes ❍ No
Eye Problems	❍ Yes ❍ No
Fainting Spells	❍ Yes ❍ No
H.I.V. Positive	❍ Yes ❍ No
Heart Disease	❍ Yes ❍ No
Heart Surgery	❍ Yes ❍ No
Hemophilia (Bleeding)	❍ Yes ❍ No
Hepatitis A	❍ Yes ❍ No
Hepatitis B or C	❍ Yes ❍ No
High Blood Pressure	❍ Yes ❍ No
Infective Endocarditis	❍ Yes ❍ No
Kidney or Liver Problems	❍ Yes ❍ No
Osteoporosis	❍ Yes ❍ No
Psychiatric Care	❍ Yes ❍ No
Radiation/Chemotherapy	❍ Yes ❍ No
Rheumatic Fever	❍ Yes ❍ No
Sinus Trouble	❍ Yes ❍ No
Thyroid Trouble	❍ Yes ❍ No
Tuberculosis	❍ Yes ❍ No
Tumors	❍ Yes ❍ No
Ulcers/Gastrointestinal Problems	❍ Yes ❍ No
Special Needs	❍ Yes ❍ No
Other: ________________________	

Patient, Parent or Guardian Signature: ________________________________ Date:_______________

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Patient Name (Please Print): ____SSN: _____________________

Patient, Parent or Guardian Signature: _________________________________ Date:_________________

AUTHORIZATION TO RELEASE INFORMATION

I authorize the following person(s) to have access to information covered under the Privacy Practices regarding the patient listed above (please list all persons who might schedule or change an appointment, and request information regarding appointments, dental care or treatment).

Name and relationship: ____

Name and relationship: ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our 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 acknowledgement
- ❑ Other (Please Specify)

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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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/7/2017, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or

privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

<u>Other Uses and Disclosures of PHI</u>

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

<u>Your Health Information Rights</u>

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Cindy J.
Telephone: (440)457-1221   Fax: (440)457-1223
Address: 6391 Royalton Rd Ste A North Royalton, OH 44133
E-mail: contact@nrfdental.com

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