COLLINS DENTAL

Reviewed by:

Although dental professionals primarily treat the area in your mouth, health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following confidential questions.

Patient Information Date_____

Patient Name_____ D.O. B _____

Nickname_____ Male or Female Single / Married / Divorced / Widowed SS# _____

Your Address_____ City_____ St_____ Zip_____

Home#_____ Cell#_____ Work#_____

Email_____

Emergency Contact_____ Relationship_____ Phone#_____

Are You A Student? Yes No Where? _____ Full / Part Time

Who Can We Thank for Referring You? _____

Dental Insurance Information

Insured's Name_____ D.O.B_____ Relationship to Patient_____

Ins Company _____ Ins Phone #_____ I.D#_____

Employer _____ Group#_____ Insured's SS#_____

Medical Health

Physician: _____ Phone#_____ Last Physical Exam_____/_____/____

General Health: Excellent___ Good___ Fair___ Poor___

Have you had any serious illness, operation, complication, been hospitalized in the past 5 years? No Yes, please explain:

_____

Are You Taking Medications? (If So What?) _____

_____

Are You Allergic To: Penicillin ___ Latex ___ Local Anesthetics ___ Codeine ___ Sulfa ___ None ___

Any Other Allergies? _____

Do You Have Any Dental Concerns? NO YES: _____

Women: Are You Pregnant or Think You May Be Pregnant? Yes No Trimester? 1 2 3 Nursing? Yes No

Indicate Which of The Following You Have Had or Have at Present. Circle Yes or No and Circle Options.

Abnormal Bleeding	YES	NO
AIDS/HIV Positive	YES	NO
Alzheimer's/Dementia	YES	NO
Anemia	YES	NO
Arthritis/Rheumatoid	YES	NO
Asthma	YES	NO
Blood Disease	YES	NO
Blood Thinners	YES	NO
Cancer	YES	NO
Chemotherapy	YES	NO
Convulsions/ Seizures	YES	NO
Digestive Disease	YES	NO
Diabetes Type 1 or 2	YES	NO
Excessive Bleeding	YES	NO

Epilepsy	YES	NO
Head Injuries	YES	NO
Hearing Impaired	YES	NO
Heart Disease	YES	NO
Heart Pacemaker	YES	NO
Heart Stent/Shunt	YES	NO
Heart Valve Replacement	YES	NO
Hepatitis	YES	NO
Type: A, B, C, D, E, F, G		
Herpes	YES	NO
High/Low Blood Pressure	YES	NO
Infective Endocarditis	YES	NO
Kidney Disease	YES	NO
Mitral Valve Prolapse	YES	NO

Multiple Sclerosis	YES	NO
Neck/Back Problems	YES	NO
Nervous Disorders	YES	NO
Osteoporosis	YES	NO
Parkinson's Disease	YES	NO
Prosthetic Joints	YES	NO
Radiation Treatment	YES	NO
Sinus Problems	YES	NO
Smoke/Chew Tobacco	YES	NO
Sleep Apnea/ CPAP	YES	NO
Thyroid Disease	YES	NO
Ulcers	YES	NO
Other:		

***For Parents of Minors: By Signing below, you are agreeing to be responsible Guardian for the minor's account and balances.**

Patient/Guardian Signature_____ **Date** _____

_____

Doctor Signature **Date**

COLLINS DENTAL

Your Dental Story

Gums Bleed While Brushing	YES	NO
Problems with Bad Breath	YES	NO
Sensitivity to Hot/Cold	YES	NO
Grind/Clench Teeth	YES	NO
Frequent Headaches	YES	NO
Clicking/Popping When Chewing	YES	NO
Snore	YES	NO

To understand what's going on in my mouth, my preference is:	
	To know / discuss all the details
	To be shown pictures and videos
	To read pamphlets and brochures

When I think about coming to the dentist I feel:	
	Comfortable – I have no anxiety. My past experiences have been pain free.
	Anxious – I make myself come but am somewhat uncomfortable.
	Fearful – I've stayed away because my past experiences have been traumatic & only come when necessary.
	Extremely fearful – I have avoided the dentist for many years to the detriment of my dental health.

On a scale of 1-10 (10 being the most) how happy are you with your smile?

 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 

I Have A Fear or Concern About:	
	Not Being Numb
	Being Numb
	Needles
	Gagging
	Loss of Control
	Being Scolded
	Made to Feel Ashamed
	Losing My Teeth
	Catching A Disease
	Cost of Treatment
	Sounds of The Dental Drill
	Waiting
	Other:

If I could change something about my smile, it would be:	
	Whiter
	Straighter
	Healthier
	Close spaces
	Repair chipped teeth
	Replace missing teeth
	Replace crowns that don't match
	Replace old fillings

COLLINS DENTAL

Notice to Our Patients

Handling of Your Insurance

So that you can be clear on how our office handles dental insurance, we wanted to share the following information with you:

Our diagnosis and treatment recommendations for you are based on what is best for your oral health and not based on what your dental insurance plan will cover or will not cover. Your benefits are related to the type of plan chosen by you and your employer. We are not a part of this contract. Often these benefits are not structured to cover the total cost of dental treatment. We will work with you and your primary insurance to get you maximum benefits and provide financial arrangements to allow you to receive your care.

As a courtesy, Collins Dental will bill your insurance company. Should a patient have secondary insurance, we will file with the insurance company; however, it is never a guarantee that the insurance company will make a payment.

If we do not hear from your insurance company within 60 days of billing, the balance will become your responsibility and it is to be paid in full. The responsibility will become yours to collect the reimbursement from your insurance company. A finance charge of 1.5 % will incur at 90 days.

My healthcare information may be disclosed to Collins Dental for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Cancellation and Broken Appointment Policy

When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us as least **48 BUSINESS HOURS** notice. This courtesy makes it possible to give your reserved room to another patient who would like it. A charge of $75 will be charged if you do not show up for your scheduled appointment or for repeated cancellations without 48-hour notice.

Repeated cancellations or missed appointments may result in loss of future appointment privileges as well. We feel that our patient's time is valuable.

Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Our goal is to deliver exceptional care for you and your family in a timely manner, and we appreciate your cooperation by honoring your scheduled appointment times.

Please sign that you have read and understand the above guidelines.

Printed Patient Name _____

Patient Signature _____ Date_____

COLLINS DENTAL

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agent embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine, for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received within 30 days treatment is completed, I understand that a 1.5% late charge may be added to my account.

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office. The practice provides this information for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Messages, Mail, Wireless Calls and Texting:

I understand you may communicate with me through US Mail, electronic mail, telephone or voice mail messages, to remind me about my appointments, or treatment follow-up. Voice mail messages may contain specific appointment information. I understand that I must tell you if I do not want you to communicate with me like this. I agree and have initialed below for Collins Dental to use an automated telephone dialing system, and texting, to contact the cellular telephone number(s) that I provided for appointment, treatment, and payment purposes.

Initial_____

I acknowledge and understand that:

- My Protected Health Information may be disclosed and used for treatment planning and decisions, securing payment from third party payers, and/or assessing quality and reviewing the competence of healthcare operations.
- I may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I wish to place the following restrictions on disclosure of my health information: _____

I give permission to *Collins Dental* to discuss my Protected Health Information with the following individuals:

Name	Relationship	Name	Relationship

I acknowledge that a copy of the *Collins Dental Notice of Privacy Practices*, which contains a more complete description of information uses and disclosures, has been made available to me and I have been given the opportunity to ask any questions that I may have regarding this notice. My consent will terminate on the last day I am seen in this office for treatment.

Patient/ Legal Guardian- Signature	Printed Name	Date

COLLINS DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 5/01/2018 and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

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

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI 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, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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 use or disclosures

permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information

Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer:

Lizbeth Kasper

5744 Canton Cove, Winter Springs, FL 32708

Phone: 407-699-9831 x211 Fax: 407-699-9896

Liz@CollinsDentalCare.com