New Patient Welcome Packet

For Office Use Only

*Date:_____

*Insurance ID:_____

Patient Name:_____

Please fill out the following information and ensure all information is correct.

Patient's Health Information

*Patient's Last Name_____ MI_____First Name:_____

*Gender: ( )Male ( )Female ( )Other Identify As: _____

Preferred Language: ( )English ( )Spanish Other _____

*Age:_____ *Date of Birth:_____/_____/_____ *Weight (Lbs):_____

*Race: ( )American Indian or Alaska Native ( )Asian ( )Black or African American ( )White

( )Native Hawaiian or Other Pacific Islander ( )Other Race ( )Declined to Specify

*Ethnicity: ( )Hispanic or Latino ( )Not Hispanic or Latino ( )Unknown ( )Declined to Specify

Reason for today's visit:_____

Last dental visit and frequency of visits:_____

* Is patient currently using prescription/non-prescription medication(s)?

( )Yes ( )No If "Yes", explain_____

*Is patient currently pregnant?

( )Yes ( )No ( )N/A If "Yes" Expected Due Date:_____/_____/_____How many weeks:_____Birth within 90 Days?_____/_____/_____

*Does patient have any dental or medical problems of special concerns?

( )Yes ( )No If "Yes", explain and provide any other information which you think might be important in the patient's care:_____

_____

* Is patient allergic to any materials commonly used in a dental office (i.e. latex gloves, anesthetic, etc.)?

( )Yes ( )No If "Yes", explain_____

* Does patient have history of joint replacement? (Hip, knee, shoulder, etc.)

( )Yes ( )No)If "Yes", explain_____

	NO	YES	Please Explain
*Does patient have any health problems?.....	( )	( )	
*Is patient under the care of a physician now?.....	( )	( )	
*Has patient ever been hospitalized?.....	( )	( )	
*Does patient bleed excessively when cut or bruise easily?....	( )	( )	
*Has patient had emotional or mental problems?...	( )	( )	
*Has patient ever had any drug reactions?.....	( )	( )	
*Has patient ever had a local anesthetic?.....	( )	( )	
*Has patient had any unfavorable dental experiences?.....	( )	( )	
*Has patient had any injuries to the mouth or teeth?.....	( )	( )	
*Does patient have a toothache today or in the past month?	( )	( )	
*Is patient allergic to any medications?.....	( )	( )	
*Is patient allergic to any foods or drink (i.e. milk, bananas)?	( )	( )	
*Does patient have environmental allergies?.....	( )	( )	

*Has patient ever had any history or difficulty with the following? If so, please mark an "X" in the spaces provided.

( ) Cancer	( ) HIV	( ) Anemia	( ) Mononucleosis	( ) Cystic Fibrosis
( ) Liver	( ) Asthma	( ) Hepatitis	( ) Cerebral Palsy	( ) Sickle Cell Anemia
( ) Lung	( ) Fainting	( ) Seizures	( ) Spinal Bifida	( ) Nervous Disorder
( ) Kidney	( ) Diabetes	( ) Convulsions	( ) Speech Problems	( ) Skin Condition
( ) Bladder	( ) Mumps	( ) Tuberculosis	( ) Cleft Lip or Palate	( ) Developmental Delay
( ) Hearing	( ) Measles	( ) Malignancy	( ) Rheumatic Fever	( ) Hydrocephaly/Shunts
( ) Smoking	( ) Rubella	( ) Hemophilia	( ) Thumb/finger sucking	( ) High Blood Pressure
( ) Thyroid	( ) Snoring	( ) Tongue Thrust	( ) Mouth Breathing	( ) Belching/Burping
( ) TMJ	( ) Autism	( ) Heart Surgery	( ) Heart Disease/Congenital Defect	

*Please explain:_____

*Smoking Status (for patients age 13 and older):

( ) Current every day smoker	( ) Current some day smoker	( ) Former smoker
( ) Light tobacco smoker	( ) Heavy tobacco smoker	( ) Unknown if ever smoked
( ) Never smoker	( ) Smoker, current status unknown	
( ) Under 13 years old		

Additional Comments_____

*CERTIFICATION AND CONSENT FOR TREATMENT

I certify that I am the parent or guardian of _____ (patient) and the information provided in this form is true and correct to the best of my knowledge. I also give my consent for my child or myself to receive a complete oral and dental examination (including any necessary x-rays) and dental cleaning. After consultation, I consent to all forms of treatment, medication, and therapy indicated for the dental care of the above named patient. This consent shall remain in full force and in effect until cancelled by either party. I understand and agree that I am responsible for any part of my bill not covered by my insurance.

Signature: _____ Relationship to Patient (if patient is minor): _____ Date: _____

Dentist Signature:_____ Date:_____

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Patient Name:_____

Family Information

*Guardian (Patient, if 18 yrs or older): Last Name_____ MI_____ First Name_____

*Gender: ( )Male ( )Female ( )Other Identify As:_____*Date of Birth: _____/_____/_____

Preferred Language: ( )English ( )Spanish Other _____

Primary Contact Information

*Street Address:_____ *City_____ *State_____ *Zip Code_____

E-Mail:_____

For your convenience, we'll contact you with important information about your appointments.

Home Phone Number: (_____) _____-_____

Cell Phone Number: (_____) _____-_____

*The office can contact me at these numbers about the patient and his/her dental care.**
( ) Yes ( ) No
**Courtesy calls and/or texts may be made with auto dialer equipment or with a prerecorded or artificial voice. While not required, opting in ensures timely appointment reminders.

*Emergency Phone Number: (_____) _____-_____

*Preferred Pharmacy: _____ *Phone Number(_____) _____-_____

*Primary Care Physician: _____ *Phone Number(_____) _____-_____

Family Members who may be seen for Treatment

	Patient's Last Name	M.I.	Patient's First Name	Patient's DOB	Patient's Medicaid Insurance # (commercial Insurance section below)
1.				/ /	
2.				/ /	
3.				/ /	
4.				/ /	
5.				/ /	

Below Only for Commercial Insurance Patients

Primary – Commercial Insurance

Name of Insured:_____ Social Security #: _____
Last First MI

Insured's Birth Date: _____/_____/_____ ID #: _____Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
City State Phone#

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name and Address: _____

Insurance Phone # (_____)_____-_____

Insurance Authorization – Please read and acknowledge by signing below

I understand payment is due before services are rendered. I authorize release of information to all insurance carriers listed above. I authorize payment directly to my doctor. I authorize my doctor to act as my agent in helping me obtain payment from my insurance. I understand and agree that any monies received directly from my insurance carrier will be my responsibility to cover costs associated with services rendered.

I understand and agree that I am responsible for any part of my bill not covered by my insurance.

_____ _____ _____
*Signature of patient, parent, or guardian *Date *Relationship to patient

New Patient Welcome Packet

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*Date:_____

*Insurance ID:_____

Patient Name:_____

Acknowledgement and Consent

*OFFICE POLICY REGARDING PATIENT TREATMENT

Our goal in treating our patients is to provide the highest quality of care utilizing the most up-to-date techniques and materials in a safe, friendly environment by our experienced, caring and well trained staff. The following are our guidelines for treatment. If you have any questions or concerns regarding these guidelines, please feel free to ask one of our dentists or staff members anytime for clarification.

TREATMENT

We will treat you and/or your child the same way we would treat ourselves or one of our own children. With very few exceptions, most children's dental treatment can be performed in the dental office with local anesthesia, nitrous oxide, and various patient guidance techniques. We feel these are safe and effective approaches to treatment for you and/or your child.

Many adults have a fear of dentistry and, as a result, they often postpone needed dental care until they have significant and complicated dental conditions. One of our goals is to demonstrate to our patients by example that regular dental visits to maintain dental health have a tremendous reward: a lifetime of healthy teeth and gums. Most of the treatment we perform (i.e., dental sealants and dental fillings) is designed to prevent future expensive and complicated dental procedures. We strive to educate our patients about dentistry and to establish a level of trust and confidence in those dental procedures aimed at preserving good oral hygiene. The result of our efforts helps to reduce the number of patients who are fearful of dentistry. Winning the trust and confidence of our patients and parents is very important and requires special attention to detail.

It is our goal to ensure every patient has a positive dental experience. We understand that every child is unique and handles new situations in different ways; however, securing a child's undivided attention is the first step toward that positive experience. Some children do not fear dental procedures and approach them with confidence. Others may feel uncertain and we understand that the presence of a parent/guardian in the clinical environment can positively or negatively impact a child's ability to provide his/her undivided attention during treatment.

We welcome parents to accompany their children in the clinical environment. For some patients, the presence of a parent/ guardian helps rather than hinders the administration of dental procedures. For other patients, however, having a parent/guardian in the room where dental care is being administered may cause the patient to be inattentive or distracted, to lose their sense of confidence, to be more likely not to adhere to the directions the clinical team provides, and/or to be disinterested in establishing rapport with the dentist providing the care. These resulting behaviors not only interfere with the dental procedure, but they can also put the patient and the clinical staff at risk as well. The office manager along with the doctor and the parents/guardians will work together to identify the most beneficial solution. After all, we believe every child deserves to have positive dental experiences and working together with our parents/guardians helps to ensure that all patients recognize us as a caring, safe, and friendly place.

PEDIATRIC DENTAL BEHAVIOR GUIDANCE TECHNIQUES

We strive to deliver professional care with the highest concern for quality of care for each child. Sometimes a child's apprehension or nervousness can interfere with the ability to treat the child's dental needs. We will attempt to obtain the cooperation and trust of the child through the use of friendly persuasive techniques such as:

Tell-Show-Do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive Reinforcement: This technique rewards the child who displays any behavior, which is desirable. Rewards may include compliments, praise, pat on the back, a high five or a prize.

Voice Control: The attention of unfocused patients is gained by changing the tone of the dentist's voice. Content of the conversation is less important than the request; however, the content should always include only appropriate requests — ones that provide clear direction while also encouraging the child.

In certain circumstances we may need to use additional methods to encourage your child to participate such as:

Mouth Props: A rubber or plastic aide is placed in the child's mouth to prevent closing when a child has trouble maintaining an open mouth.

Active Immobilization: A form of protective stabilization where the dentist/dental assistant prevents the child from moving by holding the child's hands and/or upper body, stabilizing the child's head and/or leg movements, or positioning the child to limit movement in the dental chair.

Nitrous Oxide: Nitrous Oxide/Oxygen inhalation is a safe and effective technique to reduce anxiety, produce analgesia, and enhance communication between the dentist and the patient. This is commonly referred to as "laughing gas." The patient does not become unconscious.

Passive Immobilization / Papoose Board: A form of protective stabilization where an immobilization device is used to limit the child's movements during dental procedures to prevent injury to the child and clinical team, while enabling the dentist to provide the necessary treatment. The child is comfortably placed in the immobilization device and placed in a reclined dental chair.

Note: If you have questions regarding the methods listed above, please contact a front office or clinical staff member immediately. We want your child's dental experience to be a pleasant one while also ensuring we complete any or all of your child's required dental work with your child's safety and the safety of our clinical staff in mind.

I, (parent or guardian) of _____ acknowledge that I have read and understand the "Pediatric Dental Behavior Guidance Techniques" and give consent for their use. I have been advised of the risks and benefits, as well as alternatives to include sedation, general anesthesia or deferring treatment. I further understand that this consent shall remain in effect until terminated by me. All of my questions and concerns have been addressed and answered to my satisfaction.

Signature: _____ **Relationship to Patient** (if patient is minor): _____ **Date:** _____

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Patient Name:_____

*ACKNOWLEDGMENT AND CONSENT BY PARENT/GUARDIAN TO TRANSFER AUTHORITY FOR TREATMENT

I, _____certify I am the parent and/or guardian of the following child:

_____ (the Patient). I hereby give permission to, request and authorize the following:

The listed Person(s) to transport the Patient to/from the office for examination and treatment; to accompany the Patient while at our office; and to make any and all additional decisions as needed regarding consent for the Patient's treatment. I designate and formally recognize the named Person(s) below, stand(s) in for me as the parent/guardian of the Patient at my request, are/is involved in the Patient's care and treatment, and can receive the Patient's health information and records, including any privileged or confidential information. I have already been advised of the necessary examination and treatment for the Patient. I have received sufficient consent information explaining the diagnosis, purpose of the procedures, material risks, benefits, alternatives, likelihood of success, and prognosis if rejected. I hereby request, consent to and authorize the office, doctors and staff to provide such examination and treatment to the Patient, including treatment of conditions which arise during such examination and treatment. However, to the extent additional consent is later requested, I authorize the office, doctors and staff to rely upon the below-listed Person(s) to make any and all additional decisions and sign forms regarding the Patient. I understand the office will not be held legally liable for any treatment changes or decisions made by the below-listed Person(s), and that I will be liable for costs of the Patient's care consented to by the Person(s) but not covered by Medicaid or insurance. I have been advised by the doctors and staff that it is in the Patient's best interest for the Patient's parent to be present; however, I have opted to delegate my decision-making authority to the Person(s) listed below; who will accompany the Patient and act on the Patient's behalf at my request. This form is valid for one (1) year from the date signed, and a copy is as valid as the original.

Please list ALL persons with authority to consent to treatment of the patient

None ( )

Name of Person #1_____Relationship to Patient_____ Name of Person #2_____Relationship to Patient_____

Name of Person #3_____Relationship to Patient_____ Name of Person #4_____Relationship to Patient_____

Signature: _____ Relationship to Patient (if patient is minor): _____ Date: _____

*ACKNOWLEDGEMENT OF RECEIPT AND CONSENT TO PATIENT RIGHTS AND RESPONSIBILITIES

By signing this form, you acknowledge that we have provided you with our Patient Rights and Responsibilities document (incorporated herein by reference), that you have read and understood it, and that you consent on behalf of yourself and your beneficiaries to its contents. You specifically acknowledge and understand that page 2 of Patient Rights and Responsibilities document contains a voluntary agreement to resolve any dispute that may arise in the future between the parties as defined within this document, by binding arbitration. In arbitration, a neutral third party chosen by the parties will resolve all disputes between the parties. When parties agree to arbitrate, they waive their right to a trial by jury.

THIS AGREEMENT GOVERNS IMPORTANT LEGAL RIGHTS. PLEASE READ IT CAREFULLY BEFORE SIGNING.

PATIENT OR PATIENT'S PARENT/GUARDIAN – With my signature, I certify that I am either the patient authorized to sign on behalf of myself and my beneficiaries, or the patient's parent/guardian authorized to sign on behalf of the patient and the patient's beneficiaries.

I represent that the patient has vested in me the authority to sign the agreement to arbitrate on behalf of the patient and his or her beneficiaries.

Signature: _____ Relationship to Patient (if patient is minor): _____ Date: _____

Print Name: _____

**For office use only (To be completed only if agreement is not signed)*
1. Was the patient or guardian provided a copy of the Patient Rights & Responsibilities and did he/she have an opportunity to review with you?_____
2. Indicate reason patient or guardian did not sign: _____
Office team member / Date: _____

*INFORMED CONSENT FOR PHOTOGRAPHS

Patient Photographs: Photographs will be taken when deemed necessary by the doctor for the purpose of documentation, planning treatment procedures, referrals for specialty care, or for filing insurance claims.

Permission/Denial to use photographs (initial next to your selection):

( ) I hereby grant permission to take photographs for the purpose of documentation, planning treatment procedures, referrals for specialty care, or for filing insurance claims. The photographs will be maintained as part of the patient record. By signing this form, you will consent to our use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations.

( ) I do not grant permission for taking photographs for the purpose of documentation, planning treatment procedures, referrals for specialty care, or for filing insurance claims.

I have read and understand the "Informed Consent for Photographs":

Signature: _____ Relationship to Patient (if patient is minor): _____ Date: _____

Print Name: _____

New Patient Welcome Packet

For Office Use Only

*Date:_____

*Insurance ID:_____

Patient Name:_____

OFFICE PHONE AND OTHER ELECTRONIC DEVICE POLICY

We encourage you to enjoy the use of your phone or other electronic device, with some limits, in our dental office. In order to protect the privacy of the patients, parents and staff, we do ask that you limit some uses and we help you understand those limits below.
You are free to quietly use your phone and other electronic devices in our lobby:
You may take pictures of your children (especially for their first dental visit) at the designated picture area in our lobby.
Please read, text, play games, and other quiet activities on your phone. Please turn off any audio, or use earphones. Any conversations should be quiet and discreet. Any content should be appropriate for children who could see or hear your device or conversation.

To respect the privacy and remain courteous to our patients receiving treatment, device use is limited in any treatment area:

At all times: no pictures, video or audio recording may be taken to protect the privacy of other patients receiving treatment, patients, and staff. Before treatment begins: you are welcome to use your phone for quiet activities, such as games, social media and texting. Once treatment begins: please do not use any electronic device, all people should be completely focused on supporting patient care during treatment.

If an urgent call or activity occurs, please excuse yourself to the lobby area.

I have read, understand and agree to this policy. I understand that any pictures, audio or video recording outside of those authorized above, created in the dental office, will be the exclusive property of the dental office, and I may not use, display or distribute those files in any way.

Signature: _____ Relationship to Patient (if patient is minor): _____ Date: _____

*ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices.
The Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information.

Authorization of PHI Disclosure
I authorize Personal Health Information to be disclosed to the following recipients:

None ( )

Name of Person #1: _____Relationship to you: _____

Name of Person #2: _____Relationship to you: _____

Signature: _____ Relationship to Patient (if patient is minor): _____ Date: _____

**For office use only*
To be completed only if Acknowledgement is not signed.
1. Was the patient given a copy of the Notice of Privacy Practices? [ ] YES [ ] NO
2. Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature:

_____

_____
Name/Title *Date*

Patient Rights and Responsibilities

What You Should Know and Understand About Your Dental Care

Welcome to our office - we're excited you have chosen our team as your dental care provider. Our goal as your dentist is to help you and your family establish good, healthy dental habits that will last a lifetime.

This information is really important. You should read and understand it before receiving any treatment. Here's why it's important: This document explains rights and responsibilities. It tells you what you should know and understand about dental treatment. It also lets you know exactly how we plan to provide quality dental care to you and your family.

What we both agree to:

• You are responsible for your and your family's oral health care decisions. Our team will provide information and offer professional advice, but ultimately you make the treatment decisions.

• You are responsible for practicing good hygiene habits at home (eat three healthy meals, brush twice and floss once each day). You are also responsible for coming in to the dental office for regular professional cleanings.

• You are responsible for completing any agreed treatment in order to ensure a healthy outcome. Except in the case of pain, or emergency care, we can refuse treatment to you or your family if you miss appointments without an adequate reason, are disruptive or could, in our judgment, be a risk to other patients, doctors and staff.

• We know that both our patients and doctors have busy schedules, so it is important that you are on time for all scheduled appointments. If we believe there will be a long delay while we attend to the dental needs of other patients, we will tell you and offer alternatives. We ask that you do your best to notify us at least a day in advance if you need to change or cancel your appointment.

• We will treat each other with kindness and respect. Our dental care team will strive to be attentive to your needs and we will answer any questions you may have to the best of our ability.

• Our dentists and other team members will do their best to provide high quality care to all of our patients, without regard to ethnicity, gender, national origin, religion, age, or disability. If we feel your care is best provided by someone else, we will provide you with a referral.

• We will keep details about your health, dentist visits, and treatment plans private in accordance with federal and state privacy requirements. It's your responsibility to give us honest, accurate, and complete information about your medical history and current health status so we can make the most appropriate professional recommendations about your care.

Before you begin any dental treatment:

After your exam, one of our dentists will provide a treatment plan using their best independent clinical judgment. You will have an opportunity to openly discuss this plan, and how much it will cost, with a dental professional. If you are not sure about any treatment, what it is, what it is designed to accomplish or why it is needed, you agree to discuss it with your dentist before agreeing to the treatment.

Suggested questions to ask before treatment begins:

- ❑ Are there any other treatment options?
- ❑ How much will this cost?
- ❑ How much will I owe if my insurance does not pay?
- ❑ Is there a less expensive option?
- ❑ What could happen if I go without this treatment?
- ❑ Is this treatment likely to solve my problem?

You can always decide to:

• Accept, delay, or decline any part of the treatment recommendations, including work that is already in progress.

• Use other payment options, such as credit and extended payment plans. You should always understand the additional cost if you don't pay using cash; credit options might be more costly.

• Seek a second opinion. There may be additional cost of receiving a second opinion from another dentist. Please remember that each dentist's opinion might be different. You should choose the treatment option you think is right from a dentist you trust.

• Request a copy of your medical records.

Our Commitment:

We agree to live up to these responsibilities and provide high quality dental care, protect your privacy, and be a partner on your oral health journey. We will work quickly to address any of your concerns. We want to be your dentist for the long term, so it is important to us to try to resolve any potential issues to your satisfaction.

If you have any questions about our service, your treatment, or your bill, please contact the office, the dentist, or his/her staff. Our Patient Satisfaction Hotline is available for you at any time, toll free, at 1-888-644-9144.

Patient Rights and Responsibilities

If you have a concern:

We strive to create a positive, memorable experience for you during each visit, while providing high quality dental care. As committed as we are to ensuring you have a great experience, we know that from time to time, you may have some concerns about a visit or dental treatment.

If you have a concern about your experience at our office or about a dental treatment, you should attempt to resolve the concern by first speaking with the office manager or dentist. If a satisfactory solution cannot be reached, please use the Patient Satisfaction Hotline available any time at 1-888-644-9144 to share your concerns with a trusted and experienced patient satisfaction representative.

In the unlikely event that your concern or dispute still cannot be addressed satisfactorily, by signing below we mutually agree to resolve any concern or dispute by binding arbitration according to the following agreement:

• Our office and you/patient agree to have any dispute resolved through binding arbitration by a single, independent and neutral arbitrator. Arbitration is a way to settle a dispute between us without involving courts. It's usually faster, easier, and less expensive for both of us. If you/patient agree to arbitration, the decision is considered final and you/patient cannot go to court or appeal the decision.

• We agree to arbitrate any dispute within 180 days after selection of an arbitrator, unless we both agree to a different deadline.

• The arbitration will occur at a recognized arbitration location near your/patient's residence. This agreement to arbitrate will include all people who might make a claim with or on behalf of you/patient, others making any claims on your/patient's behalf and any claims based on dental treatments provided by us to you/patient or your/ patient's family.

• You/patient will always retain the right to file a complaint with us, our dentists, or any regulatory agency. This agreement to arbitrate will not apply to disputes of an involuntarily termination of the patient-dentist relationship.

• This agreement to arbitrate will include any dispute against the office, as well as its dentists, licensed and unlicensed clinical professionals and assistants, officers, directors, employees, agents, parent entities, subsidiaries, affiliates, and any person or entity you allege to be responsible. This agreement will also include disputes involving the patient, as well as the patient's parent(s), representative, guardian, attorney-in-fact, agent, or any person whose claim is derived through or on behalf of the patient, including any spouse, child, parent, executor, administrator, personal representative, heir, or survivor, or anyone entitled to bring a wrongful death claim relating to the patient. If you are the patient's parent or guardian, the patient is an intended third-party beneficiary of this agreement.

• This agreement to arbitrate any dispute is governed by the Federal Arbitration Act and will be administered by the American Health Lawyers Association ("AHLA") or its successor, according to its rules of procedure. If the AHLA is unavailable to administer the arbitration, we will work together to identify a mutually acceptable arbitrator, and if we cannot identify a mutually acceptable arbitrator within ten (10) days after being notified about the unavailability of AHLA, then either of us may petition a court to appoint a neutral arbitrator.

• Any arbitrator selected will follow the terms of this agreement to arbitrate and the rules of the AHLA in effect at the time that our agreement was entered. The arbitrator may be removed by mutual written agreement. The arbitrator will resolve all disputes among us, including wrongful death claims and any disputes about the making, enforceability, or scope of our agreement to arbitrate.

• Each of us may be represented by our own lawyer in the arbitration. We each agree to pay our own attorneys' fees and costs, unless otherwise specifically awarded by the arbitrator. The arbitrator may award attorney's fees and expenses to the prevailing party. We will pay the fees of the arbitrator and the AHLA unless otherwise ordered by the arbitrator. We both agree that the issue of how to resolve disputes about the patient's dental care is a healthcare decision and our agreement to arbitrate is a healthcare decision. This agreement to arbitrate will become part of the patient record.

• If any part of our agreement to arbitrate is determined to be invalid, the remaining provisions of our agreement to arbitrate will remain in full force and effect.

• This agreement to arbitrate covers any subsequent care and/or treatment of the patient by our dentist. This agreement remains in effect notwithstanding the discharge of the patient from our office or the termination of the patient-dentist relationship.

• We agree that we will provide prompt dental treatment to you even if this agreement to arbitrate is not signed by you.

• You/patient, may revoke this agreement to arbitrate by providing written notice to us within thirty (30) days of your signature. Any disputes arising prior to revocation will remain subject to our agreement to arbitrate.

THIS AGREEMENT GOVERNS IMPORTANT LEGAL RIGHTS. PLEASE READ IT CAREFULLY BEFORE SIGNING. This is a voluntary agreement to resolve any dispute that may arise in the future between the parties by binding arbitration. In arbitration, a neutral third party chosen by the parties resolves all disputes between the parties. When parties agree to arbitrate, they waive their right to a trial by jury.

Joint Notice of Privacy Practices

Your Information.	This notice describes how medical information about you may be
Your Rights.	used and disclosed and how you can get access to this information.
Our Responsibilities.	**Please review it carefully.**

Your Rights - You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
-

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can request to see or obtain an electronic or paper copy of your medical record and other health information. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

Get a list of who we have shared information with

- You can request a list (accounting) of who we shared your health information with during the past six years and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Correct your medical record

- You can ask us to correct your health information that is incorrect or incomplete. Ask us how to do this.
- We may need to deny your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may deny your request if it would adversely affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a copy of this notice

- You can request a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Your Choices - You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures - We typically use or share your health information in the following ways:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A dentist treating you asks an oral surgeon for an opinion.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

Joint Notice of Privacy Practices

Our Uses and Disclosures – continued…

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. .

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual has passed.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Appointment Reminders & Patient Communications:

We will communicate reminders, confirmations and information of interest designed to improve your customer experience and oral health if you provide your contact information including, mailing address, phone number, email address and/or your opt in to text messages. We may use automated dialing technology and pre-recorded messages to confirm your appointment information, using any phone number you provide to us. Our communications to you will only disclose PHI to confirm your contact and insurance information, remind you and/or your child of an appointment, or to inform you and/or your child of treatment alternatives or other health-related benefits and services that may be of interest to you, such as oral disease management programs. Please inform us immediately if any of your contact information changes.

We may also email you or send mail to you that has information about services we offer at the office where you or other members of your family receive care.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information here.
- We will not retaliate against you for filing a complaint

You can file a complaint with our Privacy Officer

1090 Northchase Pkwy SE Suite 150
Marietta GA 30067

Email: ComplianceTeam@benevis.com
Phone: 925-817-7668
Fax: 678-285-4788

Additionally, for more information or to file a complaint you can contact the US Department of Health and Human Services Office for Civil Rights you can send a letter to:
200 Independence Avenue, S.W., Washington, D.C. 20201, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

*The HIPAA privacy rule establishes a national minimum standard. If a state law provides greater privacy protections, the state law must be observed.