Chester County Dental Arts - New Patient Registration

Dr. Mark R. Simeone DMD, AEGD
2771 East Lincoln Highway Coatesville, PA 19320 Office: 610-383-1600 Fax: 610-383-1602

Patients Name: _____ Today's Date: _____

Patient DOB: _____ How did you hear about us? _____

Home Address: _____

_____ Insurance Comany: _____

Preferred Phone #: _____ Subscribers Name: _____

Email: _____ Member ID or SSN: _____

Employer: _____ Group #: _____

Occupation: _____ Previous Dentist: _____

Emergency Contact: _____ Approx. Date of last Exam: _____

Relationship: _____ Cell: _____ Previous Office #: _____

Women:

Pregnant? Y or N Trying to become pregnant? Y or N Nursing? Y or N Taking oral contraceptives? Y or N

Allergies:

Aspirin: Y or N Penicillin: Y or N Codeine: Y or N Acrylic: Y or N Metal: Y or N Latex :Y or N Sulfa Drugs: Y or N

Are you under the care of a physician now? **Y or N** If so, why? _____
Please list all mediations and vitamins: _____
Do you use controlled substances? **Y or N** If so what? _____
Have you even been hospitalized, or had a major operation? **Y or N** If yes, what/when? _____

Do you have or have you had any of the following?

Aids/HIV Pos.	**Y or N**	Jaundice	**Y or N**	Kidney Problems	**Y or N**
Anaphylaxis	**Y or N**	Diabetes	**Y or N**	Leukemia	**Y or N**
Anemia	**Y or N**	Drug Addiction	**Y or N**	Liver Disease	**Y or N**
Angina	**Y or N**	Emphysema	**Y or N**	Low Blood Pressure	**Y or N**
Arthritis	**Y or N**	Epilepsy	**Y or N**	Lung Disease	**Y or N**
Artificial Heart Valve	**Y or N**	Frequent Cough	**Y or N**	Mitral Valve Prolapse	**Y or N**
Artificial Joint	**Y or N**	Genital Herpes	**Y or N**	Osteoporosis	**Y or N**
Asthma	**Y or N**	Glaucoma	**Y or N**	Parathyroid	**Y or N**
Blood Disease	**Y or N**	Hay Fever	**Y or N**	Mental Disorder	**Y or N**
Blood Transfusion	**Y or N**	Heart Attack	**Y or N**	Radiation Treatment	**Y or N**
Breathing Problems	**Y or N**	Heart Murmur	**Y or N**	Dialysis	**Y or N**
Cancer	**Y or N**	Pacemaker	**Y or N**	Sinus Trouble	**Y or N**
Chemotherapy	**Y or N**	Hepatitis	**Y or N**	Spins Bifida	**Y or N**
Chest Pains	**Y or N**	High Blood Pressure	**Y or N**	Stomach disease	**Y or N**
Cold Sores	**Y or N**	High Cholesterol	**Y or N**	Stroke	**Y or N**
Heart Disorders	**Y or N**	Hypoglycemia	**Y or N**	Tuberculosis	**Y or N**

Is there any other health information not listed about that Dr. Simeone should be made aware of before treating you?
If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that by providing incorrect information, it can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any medical changes.

Patient Signature: _____ Date: _____

Providers Signature: _____ Date: _____

Providers Notes: _____

_____

Chester County Dental Arts
Notice of HIPPA - Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE, TAKE YOUR TIME, AND REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Chester County Dental Arts. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Chester County Dental Arts Privacy Official:

Christina Kennedy Lawler

2771 E. Lincoln Highway

Coatesville PA, 19320

610-383-1600

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information 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 protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on February 22,2016.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and

notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written

authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is February 22,2016.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Chester County Dental Arts
Acknowledgement of receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I, _____ , have been offered/ received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____

If signing this document on behalf of a minor, please state your name and relationship to the patient.

Name: _____

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 below)

_____

_____

Chester County Dental Arts Financial Agreement

While we do not want finances to be an issue for our patients, we understand that it is not always possible to pay your dental bill in full. To make pursuing dental treatment easier for you, we offer several financial options. Please review these options carefully and choose which works best for you!

Payment options

1. Payment is due at the time treatment is rendered. We accept Cash, Check, Master Card, Visa, Discover, Care Credit and Lending Club.

2. Dental Insurance: As a courtesy to you we will submit your claim for rendered procedures to your dental insurance company. Your estimated co-payment (the amount not covered by your insurance) for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointments, we will ask that you pay the bill in full and be reimbursed from your insurance company. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded, and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

3. Monthly payment options: If a monthly payment options is best for you, we will work to try to get you approved with either Care Credit, or Lending Club. Depending on the treatment amount and your qualification, 6,12 or even 18 month interest free payment plans may be available. They also offer extended payment plans as well. You must qualify for these options.
If you feel this is the most comfortable option for you, we can submit your application today right here in the office.

Financial Agreement

1.Statements: All patients with an outstanding balance will receive a statement each month. There is a charge of $5.00 on all accounts 60 days overdue. All accounts over 90 days will be subject to our collection agency.
2. Returned Checks: A fee of $25.00 will be charged for any returned checks.
3. Broken Appointments: Our practice may charge you $45.00 for appointments broken without proper 48 hour weekday notice. We understand that emergencies occur. However, we want to make the appointment available for other patients if you are unable to make it.

I assign directly to Chester County Dental Arts LLC, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dental practice may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Chester County Dental Arts to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form please do not hesitate to ask a team member.

_____ _____

Signature of Patient or Responsible Party Print Name of Patient or Responsible Party

_____

Date

Chester County Dental Arts General Consent for Treatment

1. Health Information:
I agree to disclose all previous illnesses and medical history. Undisclosed medical information, current medications, allergies or illness are risk factors.

2. Drugs, latex and medicines:
I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases the heartbeat and, depending on my health, may be dangerous to me.

3. Needle stick:
If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.

4. Fillings, Crowns and Un-anticipated Root Canals:
Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.

5. Root Canals can fail:
Root canals can fail and may require additional treatment or the tooth may not be salvageable and need extraction.

6. Porcelain Crown, Veneers, Bonding and Cosmetic Fillings:
Porcelain crowns, veneers, cosmetic bonding and composite fillings are aesthetically pleasing; however, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.

7. Gum Treatments and Requesting "Just a Cleaning":
If I don't floss or if I smoke, I can expect to have a deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).

8. Extractions and Surgery:
I understand that all dental extractions or surgeries carry risks for example, a dry-socket following an extraction. Some risks are life threatening such as post-surgical infection or anaphylaxis.

9. Fee for Additional or Specialty Care:
I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.

10. Limitations of Insurance Coverage:
There are charges beyond what insurance will pay, e.g. nitrous oxide, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. ***I agree to be financially responsible for what insurance does not cover.***

11. 48 Hour Notice for Cancellation:
I agree to give 48-hour notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office is closed the day (or weekend) before is NOT sufficient notice.

12. Requesting Record Transfers:
Professional courtesies are between dentists. I agree not to request records until I have a new dentist.

13. Hygiene Appointments:
If I am more than 15 minutes late for my cleaning appointment, I will either take my remaining time only or reschedule and pay a broken appointment fee.

I do not expect guarantees in dental care. I have read the above and consent to the treatment.

_____ _____

Name of patient Signature of Patient

_____

Date