# HIPAA Explanation

Shorey Family Dental, PC

The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 by the US Congress to protect the privacy of your health information. The act prohibits your health care providers from releasing your health care information unless you have provided him/her with a signed HIPAA release form. Unless you have signed a release form, your health care providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care including your insurance carrier.

**A quick example from the side of the health care provider:**

In this example, we will assume your elderly mother has a dental appointment. You come to the appointment with her and ask her dental hygienist how your mother is doing. You are directed to speak with the dentist. You mother's dentist informs you that, unless your mother provides him/her with a signed release form, he/she is not permitted to provide you with information related to her dental visit.

## HIPAA Release Form

Patient Name: _____Date of Birth:_____/_____/_____

**Release of Information**

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

*Please check all that apply and provide name of individual*

☐ Parents/Guardian_____

☐ Spouse and/or Child(ren)_____

☐ Insurance Carrier_____ *necessary for claim submission

☐ Information is not to be released to anyone other than the dental insurance carrier.

*This release of information will remain in effect until terminated in writing by the patient.

**Messages**

Please call the following number to contact me_____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

**Signed:**_____Date:_____/_____/_____

# SHOREY FAMILY DENTAL PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

## Patient Information

Address: _____ Address 2: _____

City: State / Zip: Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: ☐ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Driver's license #: _____

Spouse's name: _____

Emergency name & #: _____

## Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: Rem. Deduct:

## Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: Rem. Deduct:

# SHOREY FAMILY DENTAL MEDICAL HISTORY

Patient Name: Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. 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 questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

**Women: Are you**
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

**Are you allergic to any of the following?**
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

| | | | |
|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pace Maker ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No | Yellow Jaundice ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No | |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

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

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

# Financial Policy

## Shorey Family Dental, PC

We ask that you follow these guidelines:

A. Know what your benefits are before treatment starts. If you are not sure, contact your insurance company so you know exactly how much you can expect to be covered. If you wish, we will submit a pre-treatment estimate for determination of benefits for you as long as you provide all necessary information to do so.
B. We cannot render services on the assumption that our charges will be paid by an insurance carrier. For you convenience, we will accept payments from your insurance company assigned to us by you, the insured. Such payments will be credited accordingly to your account upon receipt.
C. Please be aware, our primary financial relationship is with our patients or their families, not with the respective insurance companies.
D. Final responsibility for collection of benefits from your insurance company rests with you , the insured party.
E. Our professional services are rendered and charged directly to the patient or his/her family. The patient is ultimately responsible for payment of all fees incurred regardless of dental insurance.
F. Please be aware that your estimated out of pocket portion is expected at the time all services are rendered and will be collected at each appointment.

How does this office assist you with insurance?

A. As a courtesy to you, our office will call your insurance and obtain a basic breakdown of your dental benefits to enter into our computer system. Please note that this is only an estimate of your dental benefits and is in no way a guarantee of how your insurance will actually process any claim.
B. For your convenience, we will gladly assist you in submitting both predetermination and initial insurance claims pertaining to charges for care rendered in our office. However, please be aware our primary financial relationship is with our patients and their families, not with the respective insurance companies. Final responsibility for collection of benefits from your insurance company rests with you, the insured party. Our services are rendered and charged directly to the patient and his/her family and you are ultimately responsible for payment of all fees incurred.

By signing below, you are agreeing to assume primary financial responsibility for all services and associated charges necessary for the diagnosis, prevention and treatment of your dental health as well as that of any family member seen at our office for which you are legally responsible. You agree to pay any estimated out of pocket portion due for each and every visit to Shorey Family Dental, PC at the time of your appointment when any services are rendered. By providing us with dental insurance information, you authorize your insurance company to pay Shorey Family Dental, PC directly any amount determined by your insurance company to be a benefit of your dental insurance plan for each specific service rendered.

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Signature (Patient or responsible party) Date

# Cancellation Policy

Shorey Family Dental, PC

Patients,

Please read this notice carefully.

Please know that you are important to us and accommodating everyone is one of our top concerns. In order to be fair to all patients you must be courteous enough to allow at least 24 hours notice when changing or cancelling your appointment time.

Also, if you are more than ten minutes late to your appointment, you may be asked to reschedule.

The following fees will be in place to assist us with patient compliance in this area.

There will be a $**25** fee assessed upon a patient's 1st failed/short-notice rescheduled appointment.

There will be a $**35** fee assessed upon a patient's 2nd failed/short-notice rescheduled appointment.

There will be a $**45** fee assessed upon a patient's 3rd failed/short-notice rescheduled appointment.

After 4 failed appointments there will be no rescheduling at our office.

Patient Signature_____

Date_____