westervilledentalassociates

FINANCIAL POLICY

We are committed to providing you and your family with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our policy regarding payment for services and dental insurance.

- Payment is due as services are rendered. We accept VISA, MasterCard, Discover, American Express, Care Credit, Cash and Personal Checks.
- If you have provided us with **complete insurance information** at time of service, we will estimate your portion due and you will be asked to pay at time of service.
- We must emphasize that as health care providers, our relationship with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to our patients. In order to do this, we must have complete and accurate information regarding your insurance.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or fees they will not cover, the balance of your account or any part thereof, is your responsibility from the date that services are rendered, regardless of insurance.

Policy Regarding Minor Children

Parents of minor children are responsible for our services rendered to the children regardless of insurance coverage or court order. We are not a party to the court order, and while we will attempt to cooperate with handling of a difficult situation, the parent bringing the child to the office will be ultimately responsible for the account.

Authorization and Release

I authorize Dr. Stickel and or his agents to perform diagnostic procedures and treatment as may be necessary for proper dental care for me or child/children. I authorize release of any information concerning my or my child's dental care, advice and treatment to another dentist. I authorize release of any information concerning my or my child's dental care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group. I understand that my dental insurance carrier or payor of my dental benefits my pay less than actual bill for services, due to our office being non-participation provider. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of service not paid, in whole or in part by my dental care payor. I attest to the accuracy of the information on this document.

Patient / Guardian Date

Westerville Dental Associates

Medical History

(Please circle Yes or No)

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	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	
Are you on a special diet?	Yes	No	If yes, please explain _____
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 ☐ Sulfa Drugs ☐

Other ☐ If yes, please explain _____

PLEASE CHECK MARK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD

☐ AIDS/HIV Positive	☐ Chest Paints	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatism
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Shingles
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Sickle Cell Disease
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure*	☐ Liver Disease	☐ Sinus Trouble
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Low Blood Pressure	☐ Spina Bifida
☐ Artificial Heart Valve*	☐ Drug Addition	☐ Heart Pace Maker*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Swelling of Limbs
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Tonsillitis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tuberculosis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tumors/Growths
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Ulcers
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Venereal Disease
			☐ Rheumatic Fever*	☐ Yellow Jaundice

Condition may require medication

Information reviewed (initial year) _____/12 _____/13 _____/14 _____/15 _____/16 _____/17 _____/18

DENTAL HISTORY

TO HELP US SERVE YOU BETTER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have specific dental problems or complaints? _____

_____

When was your last dental visit? _____ What was done? _____

Do your gums bleed? _____ Have you been told you have periodontal disease? _____

If yes, when? _____ What was done? _____

Do you snore? _____ Does your spouse or significant other often leave the room because of your snoring? _____

Do you wake up at times gasping for breath? _____ Are you a restless sleeper? _____ Do you often feel tired during the day? _____

Do you have nasal congestion often? _____ When? _____

Which nasal passage? Right _____ Left _____ Both _____ Alternates _____

How do you feel about being here today? _____

I HAVE ACCURATELY COMLETED THIS FORM AND I WILL NOTIFY THIS OFFICE OF ANY CHANGES IN MY MEDICAL OR DENTAL INFORMATION.

_____ DATE _____

SIGNATURE RESPONSIBLE PARTY

WESTERVILLE DENTAL ASSOCIATES

Patient information

Today's Date

Name SSN

Sex (M/F) Date of Birth Marital Status (circle) M S W D

Address City State Zip

Home Phone Work Phone Cell Phone Other Number (to reach you during the day)

May we leave messages regarding your dental appointments at the above numbers? Home_____ Work_____ Cell_____ Other_____

Employer Name Position

Contact Information To whom may we speak about your dental concerns?

Name Phone Number Relationship

Name Phone Number Relationship

Dental Insurance Information

Policy Holder Name **SSN** **Date of Birth** **Relationship to patient**

Address (if different from above) City State Zip

Home Phone Work Phone Cell Phone Other Number (to reach you during the day)

Employer Name **Insurance Company** **Group Number**

Who else is covered on this policy?

Name SSN Date of Birth Relationship to patient

Name SSN Date of Birth Relationship to patient

Name SSN Date of Birth Relationship to patient

Who may we thank for referring you to our office? _____

Authorization and Release

I authorize Westerville Dental Associates and or his agents to perform diagnostic procedures and treatment as may be necessary for proper dental care of myself and/or my child/children.

I authorize release of any information concerning my and/or my child/children's dental care, advice and treatment to another dentist.

I authorize release of any information concerning my and/or my child/children's dental care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to Westerville Dental Associates.

I understand that my dental insurance carrier may pay less than the actual bill for services.

I understand I am financially responsible for payments in full of all accounts.

By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by my dental insurance.

I attest to the accuracy of the information on this document.

Patient or Responsible Party Date

Information Verified (initial/year) _____/08 _____/09 _____/10 _____/11 _____/12 _____/13 _____/14 _____/15

WESTERVILLE DENTAL ASSOCIATES
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information 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 or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, text messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicable do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $.50 for each page, an hourly fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

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

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

QUESTIONS AND COMPLAINTS

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

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

Contact Office Manager:

Sara Niven
6124-882-1135
627 Office Parkway
Westerville, Ohio 43082

Westerville Dental Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may Refuse to Sign This Acknowledgement *

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

_____
Please Print Name

_____
Signature

_____
Date

PLEASE NOTE:
THESE FORMS ARE REQUIRED BY THE FEDERAL GOVERNMENT,
not Westerville Dental Associates!

_____
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
___ Communications barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (Please Specify)

_____

_____

_____

4/10/2003