ART & DENTISTRY, LLC

PATIENT INFORMATION

DATE:

Name _____ Married Single Minor Male Female

Spouse's Name _____

Address _____

Social Security # _____ e-mail address _____

Birthdate _____ Telephone: _____ Home _____ Work _____ Cell

Person Responsible for Account _____ Telephone _____

Date of Birth _____ Name of Employer _____ Number _____

If Full Time Student, Name of School _____

Who should we contact in case of emergency? _____ Telephone _____

INSURANCE INFORMATION

PRIMARY INSURED	SECONDARY INSURED
Insured _____	Insured _____
SSN _____ ID# _____	SSN _____ ID# _____
DOB _____ Relationship _____	DOB _____ Relationship _____
Insurance Carrier _____	Insurance Carrier _____
Group # _____ Employer _____	Group # _____ Employer _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

AUTHORIZATION:
I hereby authorize payment directly to Art & Dentistry, LLC of the group insurance benefits otherwise payable to me. I understand that I am totally responsible for all costs of dental treatment. I hereby authorize this dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care.
The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist's of Art & Dentistry, LLC to release my dental/medical records and other information about my dental treatment to third party payors and or other health professionals by any method, including electronic transfer. There will be a $10.00 fee for any statement sent after the first request for payment, and a fee of $25.00 added to any account sent to collections.

Signature _____ Date _____

Patients Name: _____

Dental Information

Reason for today's visit: ■ Exam ■ Emergency ■ Consultation
Are you in pain? ■ No ■ Yes How long? _____
Please indicate an X if any of the following problems:

- ■ Discomfort, clicking or popping in jaw ■ Lost/Broken Filling(s) ■ Stained teeth
- ■ Red, swollen or bleeding gums ■ Teeth grinding ■ Locking jaw ■ Broken/Chipped tooth
- ■ Sensitive tooth, teeth or gums ■ Ringing in Ears ■ Bad Breath ■ Blister/ Sores in or around mouth
- ■ Other: _____

Do you require pre-medication? ■ Yes ■ No ■ Don't know
Last Dental exam: _____ Last Dental X-rays: _____
Times a day you brush? _____ Times a week you floss? _____
Have you ever been diagnosed with sleep apnea? _____ Do you use any type of appliance? _____

Medical History

List all medications you are currently taking: **(Including over the counter)**

_____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures? *(Please circle Y or N)*

Y N Heart Attack/ Stroke	Y N Thyroid Problems	Y N Cancer/ Tumors	Y N Cosmetic Surgery
Y N Heart Surg. / Pacemaker	Y N Kidney Problems	Y N Shingles	Y N X-ray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Value Prolapse	Y N Sinus Problems	Y N Arthritis/ Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/ Ulcers	Y N Artificial Bones/ Joints	Y N Diabetes/ Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizers/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/ Drug Abuse	Y N Severe/ Frequent Headaches	Y N High/Low Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw problems TMJ/TMD	Y N Back Problems	Y N Glaucoma

Please list any other medical condition(s) you have or ever had: _____

_____

Are you allergic to any of the following? ■ Latex ■ Penicillin/ Amoxicillin ■ Tetracycline ■ Aspirin
■ Dental Anesthetics ■ Other: _____
Do you use tobacco? ■ No ■ Yes/How used? _____ How much? _____ How long? _____
Please rate your general health from 1-10: _____ Do you wear contact lenses? ■ Yes ■ No
For women: Are you taking Birth Control pills? ■ Yes ■ No Are you pregnant? ■ Yes ■ No Nursing ■ Yes ■ No

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.
I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents (if any).

Signature: _____ Date: _____

UPDATE: office use only
Initials: _____ *Date:* _____ *Initials:* _____ *Date:* _____ *Initials:* _____ *Date:* _____ *Initials:* _____ *Date:* _____

ART & DENTISTRY 6500 Rock Spring Drive Ste. 110 Bethesda, MD 20814 Phone 301-564-4991 Fax 301-564-3151

ART & DENTISTRY, LLC.

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

ART & DENTISTRY, LLC.

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 (MM/DD/YR), 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 locating) 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 your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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, 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 practicably 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 will charge you $0.___ for each page, $___ per hour 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Art & Dentistry
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}

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)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Appointment Policy

We make every effort to see all patients on time and request that you extend the same courtesy to us. Appointment times are **reserved exclusively for you** and will be scheduled at times best suited for the treatment involved**.** Any change in appointments greatly affects other patients.

We require a **minimum** notice of **48 hours** for any appointment changes. **A fee of $50.00 per ½ hour** will be applied to your account **for broken or failed appointments or short notice changes**. This fee must be paid prior to any future treatment.

Financial Policy

In our efforts to keep dental costs at a minimum while maintaining a high level of professional care, we have established the financial policies:

1) Patients without Insurance Coverage :
Payment is expected at time of visit and may be paid by:
Cash, check, Visa, MasterCard American Express, or Discover

A monthly billing charge of $7.00 will be added to any unpaid balances after the 1st statement.

2) Patients with Insurance Coverage:
We will file your insurance for you providing we have been able to obtain verification of eligibility prior to your scheduled appointment.
Deductibles and estimated patient portions will be collected at the time services are rendered.
ALL fees related to any and all treatment are the full responsibility of the patient. In the event that payment is not received within 35 days from treatment date from your insurance carrier; **OR** the amount paid is different from the estimated portion, the **remaining balance** will be the responsibility of the patient.

3) Treatment consisting of several visits will require an appropriate down payment with the balance due upon completion.

4) For your convenience our office participates with Care Credit and Citi Health. This is a 3rd party medical card which will allow you to complete your planned treatment at a low interest rate, and for some treatment interest free. Please see one of our administrative staff members for more information.

5) A $25.00 charge will be added to any account sent to collections.

6) A $25.00 charge will be charged for any returned checks

7) There will be a $29.00 Administrative fee charged per person, to any account wanting copies of their records transferred.

We hope this information is helpful in answering some of the questions you may have regarding our office policies. Please feel free to discuss any questions you may have with us.
I have fully read the above information and agree with the terms and conditions.

_____ _____

Patient/Responsible Party Signature Date

Preferred Method of Appointment Confirmation

This system must be utilized due to the new care act.

Check all that apply.

Name: _____

Date: _____

- ○ Email: _____

and/or

- ○ Text: _____

----------Art & Dentistry LLC----------
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