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 HEATLTH 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 that are described in this Notice while it is in effect. This Notice takes effect August 13, 2012, 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 that we created or received before we made the changes. Before we make significant changes 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 heath 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 professional, 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 disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. You revocation will not affect any use of 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 of 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 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.

We are pleased to welcome you to our office! Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

PATIENT INFORMATION

Name: ______________________________ ______________________________ ______ ______________
Last First MI Preferred Name

DOB: _____/_____/_______ SSN: _______-_______-_________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone: (_____) _____-_______ Work Phone: (_____) _____-_______ Cell Phone: (_____) _____-_______

E-mail (*We will not share your e-mail information*): ______________________________

Address: ______________________________

Address 2: ______________________________

City: ____________________ State: ____________ Zip: ____________

Your Employer: ______________________________

Employer Address: ____________________ City: ______________ State: _____ Zip: ________

How did you hear about us? If someone referred you here, please write down their name so that we may thank them:

____

INSURANCE POLICY 1

Subscriber Name: ______________________ Subscriber ID #: ______________________

Your relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber DOB: _____/_____/_______

Insurance Company: ______________________________

Insurance Company's Phone Number (Located on the back of your card): (_______) _________-_________

Subscriber's Employer: ______________ Group Name: ______________ Group Number: ____________

INSURANCE POLICY 2

Subscriber Name: ______________________ Subscriber ID #: ______________________

Your relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber DOB: _____/_____/_______

Insurance Company: ______________________________

Insurance Company's Phone Number (Located on the back of your card): (_______) _________-_________

Subscriber's Employer: ______________ Group Name: ______________ Group Number: ____________

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature of Patient, Parent, or Guardian: ______________________________ Date: ______________

Three Lakes D.E.N.T.A.L Family & Cosmetic Dentistry

AUTHORIZATION

I hereby authorize Three Lakes Dental, P.C. to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions, whether manual or electronic. I authorize and request my insurance company to pay insurance benefits directly to Three Lakes Dental, P.C. otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient, Parent, or Guardian: ______________________________ Date: ______________

MEDICAL & DENTAL HISTORY

Name of Medical Doctor: ______________________________ City: ______________ State: ________

Emergency Contact: ______________________ Phone: (_____) ______-________ Relationship: __________

Please list all of the medications you are now taking: [ ] None

____

____

____

Please list all of the medications you are allergic to: [ ] None

____

____

Please list any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, history of rheumatic fever, etc. [ ]None

____

____

Tobacco use? [ ] Yes [ ] No If yes, what kind? ______________________ How much? ______________

Unusual reaction to dental injections? [ ] Yes [ ] No If yes, please explain: ______________________

Reason for today's visit: ______________________________ Are you in pain? ______________

Three Lakes
D . E . N . T . A . L
Family & Cosmetic Dentistry

NEW PATIENTS

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? [ ] Yes [ ] No

Do you have Bitewing x-rays that are less than 1 year old? [ ] Yes [ ] No

Name of former dentist: ______________________________ City: ______________ State: ________

Date of last Cleaning and Exam: ______/______/________

Signature of Patient, Parent, or Guardian: ______________________________ Date: ______________

PATIENT PAYMENT OBLIGATIONS AND DEFAULT PREVISIONS

I understand and agree that I am responsible for all treatment charged not covered by insurance. I understand and agree to pay all charges not covered by insurance upon demand by Three Lakes Dental, P.C.. If I fail to pay upon demand for payment by Three Lakes Dental P.C., then I agree to pay all costs of collection to include a reasonable attorney's fee. Further, I agree to pay a service charge of 1.5% per month (18% per annum) for any unpaid balance on my account.

Signature of Patient, Parent, or Guardian: ______________________________ Date: ______________

Family & Cosmetic Dentistry
1619 Gilmer Avenue
Tallassee, AL 36078
(334) 252-9000
www.3LakesDental.com

Records Request Form

Please complete the following Records Request form. Three Lakes Dental, P.C. will request a copy of your records from your previous dentist's office on your behalf.

Dr.: ____

City: ______________________________ State: ______________

I hereby authorize you to release a copy of dental records for the following persons/accounts to Three Lakes Dental, P.C.. (Please list the name and DOB of the patient(s) here:

Patient Name: ______________________________ DOB: ____/____/______

Patient Name: ______________________________ DOB: ____/____/______

Patient Name: ______________________________ DOB: ____/____/______

Patient Name: ______________________________ DOB: ____/____/______

Patient Name: ______________________________ DOB: ____/____/______

Authorizing Signature: ______________________________

Please Print Name: ______________________________

Date: ____/____/______

Authorization to Disclose Health Information to Family Members and Friends

Patient Name: ____ Date of Birth: ________/________/__________

I hereby authorize Three Lakes Dental, P.C. ("TLD") to release my patient health information as described below:

		Type of Information Allowed to Disclose (check one or both)		Method of Disclosure (check all that apply)		
Name	Relationship	Medical	Billing	By Phone	In Person	By Email

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments, and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance, and insurance claims status.

I understand that the Health Insurance Portability and Accountability Act ("HIPAA"), and its implementing regulations govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization as set forth in TLD's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization, and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer" at TLD.

I understand that I am not required to sign this Authorization and that TLD may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

(Check One): **I DO** ____ **DO NOT** ____ **GIVE PERMISSION** to Three Lakes Dental, P.C. to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of TLD. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this Authorization. If you choose not to authorize any family members or friends for disclosure of PHI, TLD will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

____ ____

Signature of Patient or Personal Representative (i.e. Guardian) Relationship of Personal Representative to Patient

Date of Authorization: ________/________/__________