FRANKLIN DENTAL ASSOCIATES

DATE: _____

PATIENTS NAME _____
FIRST MIDDLE LAST

PREFERRED NAME _____

DATE OF BIRTH _____ MARITAL STATUS _____ SOCIAL SECURTITY # _____

ADDRESS _____

_____

PARENT OR GUARDIAN _____
(FOR PATIENTS UNDER 18 YEARS OF AGE)
NAME PARENT SS# PARENT DATE OF BIRTH

TELEPHONE (H) _____ (C) _____ (W) _____

MUST HAVE 2 WAYS TO CONTACT

EMAIL _____

PREFERRED METHOD OF CONTACT – MARK 1ST, 2ND, & 3RD CHOICES

HOME ____ CELL ____ WORK ____ TEXT ____ EMAIL ____

(WE STILL HAVE TO HAVE A 24 HOUR NOTICE FOR CANCELLATION TO AVOID A BROKEN APPT FEE CHARGED

PLACE OF EMPLOYMENT _____

EMERGENCY CONTACT _____ TELEPHONE _____

PRIMARY DENTAL INSURANCE _____ EMPLOYER _____

INSURED _____
NAME SS # DATE OF BIRTH

SECONDARY DENTAL INSURANCE _____ EMPLOYER _____

INSURED _____
NAME SS # DATE OF BIRTH

PERSON RESPONSIBLE FOR PAYMENT _____

REFERRED BY _____

YOUR ANSWERS ARE FOR OUR RECORDS AND WILL BE CONSIDERED CONFIDENTIAL.

ALL RECORDS IN OUR DENTAL OFFICE ARE HIPPA CONPLIANT.

COMPLETE BACK ALSO

PLEASE ANSWER THE QUESTIONS BELOW – IF YES PLEASE EXPLAIN ON THE BLANK PROVIDED

1. ARE YOU IN GOOD HEALTH? _____ YES NO
2. DO YOU HAVE OR HAVE YOU EVERY HAD?
   - ANEMIA _____ YES NO
   - DIABETES _____ YES NO
   - ASTHMA _____ YES NO
   - HIGH BLOOD PRESSURE _____ YES NO
   - ABNORMAL HEART CONDITION _____ YES NO
   - RHEUMATIC FEVER/ MITRAL VALVE PROLAPSE _____ YES NO
   - PROSTHETIC HEART VALVE/HEART MUMOR _____ YES NO
   - CANCER (DESCRIBE TYPE) _____ YES NO
   - ARTHRITIS OR SWOLLEN JOINTS _____ YES NO
   - JOINT REPLACEMENT/IMPLANTS _____ YES NO
   - ANY FOREIGN OBJECTS _____ YES NO
   - IMMUNE SYSTEM PROBLEMS _____ YES NO
   - KIDNEY TROUBLE _____ YES NO
   - EPILEPSY _____ YES NO
   - HEPATITIS OR LIVER DISEASE _____ YES NO
   - PERSISTENT COUGH OR TUBERCULOSIS _____ YES NO
   - AIDS OR HIV INFECTION _____ YES NO
   - SEXUALLY TRANSMITTED DISEASES _____ YES NO
3. HAVE YOU HAD ABNORMAL BLEEDING OR REQUIRED A BLOOD TRANSFUSION ANEMIA _____ YES NO
4. ARE YOU ALLERGIC TO:
   - LOCAL DENTAL ANESTHETICS _____ YES NO
   - PENICILLIN OR OTHER ANTIBIOTICS _____ YES NO
   - SULFA DRUGS _____ YES NO
   - ASPIRIN _____ YES NO
   - ACETAMINOPHEN _____ YES NO
   - CODEINE OR OTHER NARCOTICS _____ YES NO
   - LATEX _____ YES NO
   - OTHER _____ YES NO
5. ARE YOU TAKING ANY DRUGS OR MEDICATIONS?

   IF YES, WHAT? _____ YES NO
6. ARE YOU PREGNANT OR NURSING _____ YES NO
7. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED THAT WE SHOULD KNOW ABOUT? _____ YES NO

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE. I ACKNOWLEDGE THAT ANY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF THE STAFF, RESPONSIBLE FOR ANY ERROR OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETEION OF THIS FORM.

SIGNATURE OF PATIENT/GUARDIAN _____

Franklin Dental Associates

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Franklin Dental Associates. I hereby authorize, as indicated by my signature below, Franklin Dental Associates to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an unencrypted email/text message at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

4. _____ Date Added / Removed: _____

* * *

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 the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

FRANKLIN DENTAL ASSOCIATES, PLC
490 S MAIN ST, STE 201
ROCKY MOUNT VA 24151
(540)483-5241

WRITTEN FINANCIAL POLICY

Thank you for choosing Franklin Dental Associates, PLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENTS OPTIONS:
You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- Convenient Monthly Payment Plans from Care Credit
  - -Allows you to pay over time
  - -No annual fees or pre-payment penalties

Please Note:
Franklin Dental Associates, PLC requires payment due at time of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in 2 payments for treatments over $825. For plans requiring multiple appointments, payment can be made at time of service or patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A FEE OF $50 IS CHARGED FOR PATIENTS WHO DO NOT SHOW FOR SCHEDULED APPOINTMENTS OR CANCEL WITHOUT GIVING A 24 HOUR NOTICE.

If we are unable to confirm your appointment due to incorrect phone #'s, your appointment will be cancelled. We will make every attempt possible.

Franklin Dental Associates PLC charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Franklin Dental Associates
Notice of 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 REVIEW IT CAREFULLY.

Franklin Dental Associates, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 10/31/2014. You may access or obtain a copy according to the following options: 1) contact the office and request a copy to be sent to you by mail or email, 2) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.

A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.

B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.

C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff.

i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

E) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.

F) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.

G) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released

to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

H) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.

B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).

C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.

D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.

E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.

F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.

G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.

H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

Franklin Dental Associates
490 South Main Street, Suite 201
Rocky Mount, Virginia 24151
TEL: (540) 483-5241
information@franklindentalassociates.net

You will not be penalized for filing a complaint.