

Kluth Richardson Family and Cosmetic Dentistry

PLEASE PRINT

Patient Info:

Name: _____ Preferred Name: _____
Birthdate: _____ Social Security Number: _____
Male: _____ Female: _____ Child: _____ Single: _____ Divorced: _____ Married: _____
Address: _____ City: _____
State, Zip: _____ Employer: _____
Cell#: _____ Work#: _____
Home#: _____ Email: _____
Where can we contact you between the hours of 8-5? _____
How did you hear about our office? _____
Is anyone in your household a current patient at our office? YES NO
Name: _____
Emergency Contact Phone: _____
Emergency Contact Name/Relationship to you: _____

Responsible Party Info:

Name: _____ Birthdate: _____
Address: _____ City: _____
State, Zip: _____ Best Phone #: _____

Insurance Primary: (Present your Insurance Card and Photo ID to Front Desk.)

Insured Name: _____ Insured Date of Birth: _____
Relationship to patient: _____ Insured Social Security Number: _____
Insurance Company Name: _____ Insurance ID#: _____
Place of Employment of the insured: _____
Phone number for insured's employer: _____

Previous Dentist Name & Address: _____
Last Visit: _____ How would you rate your smile 1-10? _____
What would you change about your smile? _____

Medical History:

Name of physician: _____ Phone#: _____
Last visit with Physician: _____ Address: _____

Do you smoke? YES NO Do you use chewing tobacco: YES NO

Do you vape? YES NO Do you use a nicotine pouches? YES NO

Do you or have you ever been told you snore? YES NO

Are you currently taking prescription or non-prescription medication? : YES NO

If yes, please list: _____

Have you ever had, or been treated for any of the following: **CIRCLE ALL THAT APPLY**

Psychiatric Problems	Tuberculosis	Heart Attack	Stroke	Hepatitis	Epilepsy
Cancer	Aids/HIV	Heart Murmur	Anemia	Kidney problems	
High Blood Pressure	Diabetes	Abnormal Bleeding	Drug Alcohol abuse	Artificial Joints	

Have you been treated for any other illness not listed? YES NO

If yes, please explain further: _____

Have you been instructed by your physician to take a pre-medication (antibiotic) before dental appointments? (For medical conditions such as, artificial joint, heart problems, etc.) YES NO

If yes, what antibiotic does your physician require you to take: _____

Do you take medication that are Bisphosphates/ or medication for osteoporosis? _____

Would you be interested in receiving information about medication we can give you before a procedure to relax you or make your anxiety less severe? **(Some do require a driver)** YES NO

Allergies: **(Circle all that apply)** Penicillin Aspirin Codeine Erythromycin
Latex Sulfa Dental Anesthetic

Please list other allergies: _____

Women only:

Are you pregnant? YES No Due Date: _____

Are you nursing at this time? _____

Are you taking any hormone replacement therapy? _____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis for my dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to use all anesthetics, sedatives and other medications as the doctor deems necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete copy of any possible complications
4. I agree to be responsible for payment of all services rendered on mine or my dependents behalf. I understand payment is due time of service. I understand if insurance has not paid within 90 days, the balance is my responsibility. I understand interest and a late fee could be assessed to any outstanding balance on my account. I also agree that should it be needed, I will be responsible for any and all collection costs, which may include but are not limited to attorney fees, collection costs and court costs.
5. I understand that a 48 hour notice must be given to cancel or reschedule an appointment. I realize that a \$50.00 fee may be assessed to my account if I fail to give proper notice. I realize that the doctor has the right to refuse to save time for me again in the schedule if I fail to give a 48 hour notice. If more than 3 appointments are missed or rescheduled on short notice the doctor reserves the right to dismiss you as a patient from this office. If this does happen your records will be sent to another dentist of your choice.
6. I also give permission for the doctor or his staff to use any photos they may take for lecturing, education or promotional purposes.
7. PLEASE UNDERSTAND THAT YOU ARE RESPONSIBLE FOR KNOWING AND UNDERSTANDING YOUR INSURANCE LIMITATIONS AND BENEFITS.

Printed Name of Patient: _____ Date: _____

Signature: _____

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 (07/01/09), 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. **Your Authorization and Consent:** 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.

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

Payment: We may use or disclose your health information as necessary for payment purposes. During the normal business course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use information to prepare a bill to send to you or to the person responsible for your payment.

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.

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.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or alternative locations. For example: if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such a request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we no send you any future marketing materials and we will use our best efforts to honor such request. You must make requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Business Associates: Aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of outside people or organization who assist us with our health care operations. In all cases, we require these associations to appropriately safeguard the privacy of your information.

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

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such a request in writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an

Institutional Review Board which oversees that research or by representations of the researchers that limit their use and disclosure of your information.

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 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.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to Your Protected Health Information: You have the right to copy and/or inspect a lot of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient's Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies, you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obliged to make the requested amendments, but we will give each request careful consideration. All amendment requests must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for dental records.

Restrictions on Use and Disclosures of Your Protected Health Information: You have the right to request restrictions on use and disclosures of your protected health information for treatment, payment or healthcare operations. We are not required to agree to most restrictions requests but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan. If the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law, and the protected health information pertains solely to a healthcare item or services of which you, or someone other than the health plan on your behalf, has paid Kluth Richardson Family & Cosmetic Dentistry in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communication your desire to do so to the individual responsible for dental records.

Right to Notice of Breach: We take very seriously the confidentiality of your patient's information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event of a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have the right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Office at the address below.

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.

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: Torie Richardson or Kelly Jarrell
Telephone: 317-770-1050 Fax: 317-770-1645
Email: noblesville@kluthrichardsondental.com
Address: 16000 Prosperity Drive Suite 400, Noblesville, Indiana 46060

Initial Date _____
Updated Date _____



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.

Patient's Printed Name

Signature of person completing this form (and relationship to patient)

Date: _____

Name of person's/or entities who are allowed to inquire about patients treatment. **(PLEASE PRINT)**

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 acknowledgement
- Other: _____