CARING FOR KIDS & PARENTS

"Adult and Cosmetic Dentistry with a Caring Touch"

http//www.caring4kids.com

Clear form

901 Enterprise Pkwy, Suite 500
Hampton, Virginia 23666
Phone: (757) 896-4900
Fax: (757) 896-4905

CONFIDENTIAL

PATIENT INFORMATION

Email _____ Date _____

Legal Name _____ Name Called _____ Birth Date _____

Sex: ☐ M ☐ F Marital Status: (Please check one) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address _____ Zip Code _____ Home Phone _____

Employer _____ Mobile/Pager Phone _____ Work Phone _____

Social Security Number _____ Whom may we thank for referring you? ☐ Friend ☐ Yellow Pages ☐ Dentist

☐ Other _____

In case of an emergency, who should be notified? _____

Name _____ Phone _____

Are any of your family members patients here? ☐ Yes ☐ No If so, who? _____

Person responsible for payment of account (person's name to appear on billing statement) ☐ Self ☐ Spouse ☐ Parent or Guardian

☐ Other _____

If you checked "self," please skip this section and go on to the third section

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name _____ Birth Date _____ ☐ M ☐ F

Home Address (If different from above) _____ Phone _____

Employer _____ Social Security Number _____

Business Address _____ Phone _____

PATIENT'S SPOUSE (OR PATIENT)

Name of Spouse or Parent or Guardian _____ ☐ M ☐ F

Employer _____ Social Security Number _____

Business Address _____ Phone _____

INSURANCE INFORMATION

Dental Insurance ☐ Yes ☐ No Effective Date _____ Medical Insurance ☐ Yes ☐ No Effective Date _____

Insurance Company _____ Insurance Company _____

Insured's Name _____ Insured's Name _____

Group No. _____ Contract No. _____ Group No. _____ Contract No. _____

SECONDARY INSURANCE

Dental Insurance ☐ Yes ☐ No Effective Date _____ Medical Insurance ☐ Yes ☐ No Effective Date _____

Insurance Company _____ Insurance Company _____

Insured's Name _____ Insured's Name _____

Group No. _____ Contract No. _____ Group No. _____ Contract No. _____

CARING *for* Kids & Parents

MEDICAL HISTORY

Patient Name _____ Email _____ Date of birth _____

Address _____ Home Phone _____

Cell Phone _____ Work Phone _____

Physician's Name _____ Physician's Phone _____

Insurance Name _____ ID# _____ Insured's Name _____

Are you taking **any** medication now? ☐ Yes ☐ No If yes, please list _____

Are you pregnant? ☐ Yes ☐ No Have you ever had a sleep test? Yes No CPAP machine ever been recommended? Yes No

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No	Are you allergic or had a reaction to:	Yes	No
AIDS	☐	☐	High Cholesterol	☐	☐	Prolonged Bleeding	☐	☐			
Allergies/Hay Fever	☐	☐	Hemophilia	☐	☐	Rheumatic Fever	☐	☐	Local anesthetics	☐	☐
Arthritis	☐	☐	Hepatitis A, B, or C	☐	☐	Sinus Condition	☐	☐	Penicillin/other antibiotics	☐	☐
Blood Transfusions	☐	☐	Heart Murmur	☐	☐	Skin Disease	☐	☐	Sulfa Drugs	☐	☐
Cancer	☐	☐	Joint Replacement	☐	☐	Stroke	☐	☐	Barbiturates/sedatives	☐	☐
Congenital Heart Defects	☐	☐	Kidney Disease	☐	☐	Thyroid Disease	☐	☐	Sleeping Pills	☐	☐
Diabetes	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐	Aspirin	☐	☐
Emphysema	☐	☐	Low Blood Pressure	☐	☐	Ulcer	☐	☐	Wine or Foods	☐	☐
Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease	☐	☐	Codeine	☐	☐
Frequent Headaches	☐	☐	Pace Maker	☐	☐	Psychological Disorder	☐	☐	Other Narcotics		

Additional information about your health that we should know: _____

Have your recently been hospitalized? _____, if so, when: _____

Were you ever advised by your doctor to have antibiotics before any medical or dental treatment? ☐ Yes ☐ No

Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No

Is so, please explain: _____

DENTAL HISTORY

	Yes	No		Yes	No
Bleeding Gums?	☐	☐	Do you use recreational drugs? If so, how often? _____	☐	☐
Bad Breath?	☐	☐	Do you consume alcohol? If so, how often? _____	☐	☐
Sore areas in your mouth?	☐	☐	Do you use smokeless tobacco?	☐	☐
Pain in or near your ears?	☐	☐	Do you have a specific dental problem or pain?	☐	☐
Sensitivity to heat, cold or sweats?	☐	☐	Are you happy with your smile? If not, why? _____	☐	☐
Frequent headaches or tied jaws?	☐	☐	Do you smoke?	☐	☐
Have you ever been treated by a Periodontist? (Gum Specialist)	☐	☐	Date of your last dental visit? _____		
Have you ever been treated by an Orthodontist? (Braces)	☐	☐			

Were Panoramic (Full mouth x-rays) taken within the last 3 years that we can obtain from your previous dentist? ☐ ☐

AUTHORIZATION

I (we) the undersigned authorize treatment by the doctor and supporting staff members.
I (we) understand there may be a minimum charge of $80.00 for broken appointments without 48 hours notice.
I (we) authorize assignment of insurance benefits where applicable. If payment has not been received from the insurance company within eight (8) weeks, I will accept full responsibility for payment.
I (we) assume full responsibility for balance of charges not covered by insurance company and agree to pay my estimated portion of charges at time of services rendered.
I (we) accept full responsibility for any legal or attorney fees for collection should my account become delinquent.
I (we) understand there will be a $10.00 monthly rebilling fee added to any account that is delinquent.

Patient or Guardian's Signature _____ Date _____

ABOUT DENTAL INSURANCE

If you have dental insurance, payment is your responsibility, but we can help. Regardless, of what we might calculate as your dental benefits in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. Dental insurance is not a pay-all, but is a great supplement to allow you to obtain the highest quality of dentistry available. As a courtesy to you, we do accept assignment of benefit payments for most insurance companies. This will reduce your immediate out-of-pocket expenditures. Our estimates are based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make payment. After this time, all inquires, follow-ups, and payments due, become your responsibility.

I understand that I am responsible for ALL fees regardless of insurance coverage. Interest charges of 1.5% per month (18% per year) will be added to the entire unpaid balance after 60 days. I agree to pay all cost of collection, including, but not limited to, reasonable attorney's fees.

_____ _____

Signature **Date**

Clear form

HIPAA CONSENT PDRM

From the office of: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but i f we do, we shall honor that agreement

By signing this form, you consent to our use and disclosure of protected health information about you for treatment payment and healthcare operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that

- Protected health information (PHI) may be disclosed or used for treatment payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient

Patient gives office permission to use any contact written on patient registration form.

Please check any that you **DO NOT** want the office to call, we will be using the numbers/emails you have updated, on your Account information. All information is subject to availability to verify and validate.

___ Work Cell	___ Work Phone	___ Work Email	___ Work Fax	___ Mail to Work
___ Personal Cell	___ Home Phone	___ Home Email	___ Home Fax	___ Mail to Home
___ Emerg. Contact	___ Interpreter Contact			
___ Any of the above				

List names of who can have access to your dental/medical chart information: Circle Type.

State what part of your chart: Financial, Treatment, Health history, is allowed to be disclosed or copied

_____ Full access / Partial access _____

_____ Full access / Partial access _____

Patient gives office permission to forward any verified contact information and PHI to patients' specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives Involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See **45 CFR 164.506**. Any source other than your Healthcare Providers, will sign a Business Associate Agreement Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients' case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name _____ Date _____

Print Legal Guardian's Name _____ Date _____

Signature of Patient or Legal Guardian _____ Date _____

___ Patient refused to sign HIPAA Consent Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature _____ Printed Name _____ Date _____

Witnessed Staff Signature _____ Printed Name _____ Date _____

CARING for Kids & Parents

The law in Virginia provides that whenever any person who is rendering health care services to a patient is directly exposed to the patient's body fluids in a manner that may, according to the current guidelines of the Center for Disease Control, transmit human immunodeficiency virus (AIDS virus) or Hepatitis B or C viruses, the patient will be deemed to have consented to testing for infection with the AIDS virus and Hepatitis B or C viruses without actual consent but with knowledge. The results of this test will be released to the person who is exposed to body fluids, also without actual consent.

_____ _____

Signature of Patient or Guardian Date

Mike McCormick, DDS
General Dentistry
Pamela McDonald, DDS
Pediatric Dentistry
Walt Wexel, DDS
Orthodontist

901 Enterprise Parkway
Suite 500
Hampton, Virginia 23666
757-896-4900
Fax 757-896-4905

CARING FOR KIDS & PARENTS

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 *4/14/03,* 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 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, 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 $_____ 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: Michael P. McCormick, Jr. D.D.S.

Telephone: (757) 896-4900 **Fax:** (757) 896-4905

Address: 901 Enterprise Parkway – Suite 500 – Hampton, VA 23666