RANDOLPH DENTAL
COMPREHENSIVE DENTAL SERVICES

Privacy Policy

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing dental health care services to you, to pay your dental health care bills, to support the operation of the dental practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your dental health care and any related services. This includes the coordination or management of your dental health care with a third party. For example, your protected health information may be provided to a dentist of physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but

are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home or cellular number and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office for an accounting or insurance matter. We may also mail a postcard reminder or billing statement to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.
Your dentist is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively

(i.e. electronically).
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer, MIchelle, of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

Randolph Dental
320 North 3rd St
7th Floor
Burlington, IA 52601
319-753-1600

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)

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

RANDOLPH **DENTAL**
COMPREHENSIVE DENTAL SERVICES

OFFICE PAYMENT POLICY

The following is an outline of our office payment policies. Please acquaint yourself with them and then sign below to acknowledge your understanding and acceptance of them.

FEES

Please feel free to discuss our fees with us at any time. Before any dental treatment begins, the patient and/or responsible party will receive a consultation regarding treatment plan and cost. We attempt to keep our fees at a fair level that reflects the quality of care provided in our office. Prompt payment will enable us to keep our fees lower for everyone; therefore, **payment is due at the time services are rendered**. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required.

We accept cash, check (returned check fee $20), Visa, MasterCard, and Discover. We also offer financing options with no interest up to 12 months where applicable, or longer payment terms with competitive interest rates through Care Credit.

INSURANCE

As a courtesy to our patients with insurance, we will file your insurance claim and allow you to pay only your deductible and/or estimated co-payment as services are rendered. This amount is also due at the time of the appointment. Please remember that the contract is between you and your insurance company, and **your total balance in our office is always your responsibility**. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your insurance policy or payment from your insurance. If for any reason there is a balance remaining after your insurance company's payment, you will be billed for that amount with a statement. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier. We will assist in obtaining payment from the insurance company in any way we can.

PAST DUE ACCOUNTS

Account aging begins the day your charges are incurred. Unless arrangements are made in advance, accounts that are 60 days past due will begin to incur an interest charge of 1.5% per month (18% per annum) on the outstanding balance until the account is paid in full. Accounts that are ninety (90) days past due without any effort to make payment will be turned over to a third party collection agency. This action may cause an additional maintenance fee to be added to your account. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care. You will also lose any implied or expressed warranties related to completed or in progress work.

I have read, understand and agree to adhere to the financial policies outlined above.

#________________________________

Full Name________________________ Date_________________________

Health History Form

American Dental Association
www.ada.org

E-mail: | Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last / First / Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: | Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	**No**	**DK**
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	**No**	**DK**
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

____

____

____

____

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Form S500

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: ____________ If yes, have you had any complications? ____________			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: ____________			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? ____________			
If yes, how much do you typically drink In a week? ____________			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: ____________			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ____________	☐	☐	☐
Aspirin ____________	☐	☐	☐
Penicillin or other antibiotics ____________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____________	☐	☐	☐
Sulfa drugs ____________	☐	☐	☐
Codeine or other narcotics ____________	☐	☐	☐
Metals ____________	☐	☐	☐
Latex (rubber) ____________	☐	☐	☐
Iodine ____________	☐	☐	☐
Hay fever/seasonal ____________	☐	☐	☐
Animals ____________	☐	☐	☐
Food ____________	☐	☐	☐
Other ____________	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ____________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ____________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ____________			
Recurrent Infections	☐	☐	☐
Type of infection: ____________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments: ____________

HIPPA Disclosure for Family Member / Friend

I, ____________________________, direct my healthcare and medical services providers to verbally disclose my protected health information described below.

Name	Relationship	Phone Number

Health Information to be __verbally__ disclosed upon the request of the person named above:

A. Share information from my complete health record including but not limited to diagnoses, prognosis, treatment, and billing, for all conditions

This consent shall be effective for (Check one):

☐ All past, present, and future appointments, **OR**

☐ Specific Date or Event:______________________________________

This authorization shall remain effective upon the date of my signature and continue until I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your healthcare provider)

______________________________________ ______________________________
Name of the Individual Giving this Authorization Date of Birth

______________________________________ ______________________________
Signature of the Individual Giving this Authorization Date