

# Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. (Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.)

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 (04/14/03), 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 \$0.25 for each page, \$1.50 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.

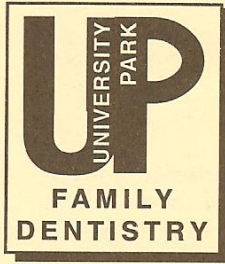
Contact Officer: Stephanie JiUjiskv

Telephone: (574) 272-4441

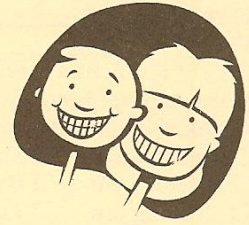
Fax: (574) 968-0689

E-mail: uofamdentistry@hotmail.com

Address: 16597 State Road 23 South Bend IN 46635



University Park Family Dentistry  
Jeffrey A. Turner, DDS  
16597 State Road 23  
South Bend, IN 46635  
(574)272-4441



### Patient Information

Name \_\_\_\_\_ Soc Sec# \_\_\_\_\_  
Last Name First Name M.Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Divorced

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

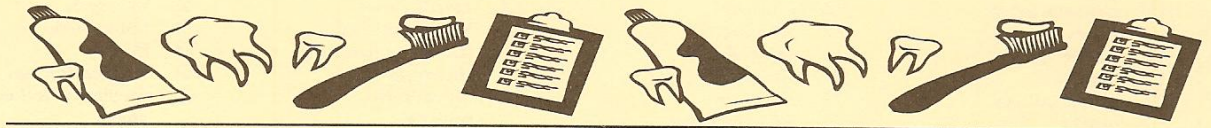
Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_



### Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name M.Initial

Relationship \_\_\_\_\_ Birth date \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber# \_\_\_\_\_

If you have secondary coverage please provide front desk with your insurance card.  
Please read our office's policies on secondary insurance coverage.

over ↓

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ May we contact your former dentist for current records?  Yes  No

Date of last dental care? \_\_\_\_\_ Date of last x-rays? \_\_\_\_\_

Have you ever been advised to pre-medicate with an antibiotic prior to dental treatment?  Yes  No

Check  if you have had problems with any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Bad Breath    | <input type="checkbox"/> Food collection between teeth  | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to sweets     |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Grinding or clenching teeth    | <input type="checkbox"/> Sensitivity to Cold   | <input type="checkbox"/> Sensitivity to biting     |
| <input type="checkbox"/> Clicking jaw  | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to Hot    | <input type="checkbox"/> Sores or growths in mouth |

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction in conjunction with a medical or dental procedure?  Yes  No

Other information about your dental health or previous treatment \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Yes  No

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

Women: Are you pregnant?  Yes  No Nursing?  Yes  No Taking Birth Control Pills?  Yes  No

Check  whether you have or have had any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Cortisone treatments         | <input type="checkbox"/> High Blood Pressure                                | <input type="checkbox"/> Respiratory disease            |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Cough, persistent            | <input type="checkbox"/> Jaw Pain   | <input type="checkbox"/> Rheumatic/Scarlet fever        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough up blood               | <input type="checkbox"/> Kidney Disease or malfunction                      | <input type="checkbox"/> Shingles                       |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Liver Disease                                      | <input type="checkbox"/> Shortness of breath            |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Epilepsy                     | <input type="checkbox"/> Material Allergies (Latex, wool, metal, chemicals) | <input type="checkbox"/> Skin rash                      |
| <input type="checkbox"/> Artificial joints       | <input type="checkbox"/> Fainting                     | <input type="checkbox"/> Mitral valve prolapse                              | <input type="checkbox"/> Spina Bifida                   |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Food allergies               | <input type="checkbox"/> Nervous problems                                   | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Atopic (allergy prone)  | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Pacemaker/Heart Surgery                            | <input type="checkbox"/> Surgical implant               |
| <input type="checkbox"/> Back problems           | <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Psychiatric care                                   | <input type="checkbox"/> Swelling of feet or ankles     |
| <input type="checkbox"/> Blood disease           | <input type="checkbox"/> Heart Murmur                 | <input type="checkbox"/> Rapid weight gain or loss                          | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Problems, Describe_    | <input type="checkbox"/> Radiation treatment                                | <input type="checkbox"/> Tobacco habit                  |
| <input type="checkbox"/> Chemical dependency     | <input type="checkbox"/> Hemophilia/Abnormal bleeding |   | <input type="checkbox"/> Tonsillitis                    |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Herpes                       |   | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Circulatory problems    | <input type="checkbox"/> Hepatitis                    |   | <input type="checkbox"/> Ulcer/Colitis                  |
|  |   |   | <input type="checkbox"/> Venereal disease               |

Is patient currently taking any medications? If yes, list all: \_\_\_\_\_

Does patient have drug allergies? If yes, list all: \_\_\_\_\_

### Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

5/04

Payment is due in full at the time of service, unless prior arrangements have been approved

## How may we contact you?

I agree to allow University Park Family Dentistry to use the following methods to contact me regarding my treatment and/or my appointments, if none of the following are checked, University Park Family Dentistry may leave a message at any of my contact numbers recognizing Dr. Jeffrey Turner's office.

Please check all that applies:

At home, leave a message (circle all that applies) with family member and/or on an answering machine.

At work, leave a message (circle all that applies) on a machine and/or with a co-worker.

Alternate form of contact, please describe \_\_\_\_\_

## Financial Policies

If you have insurance benefits and any information has changed, please provide us with your new insurance card. A co-payment may still be required even if YOU have full benefit coverage. Payment for services rendered is due at the time of service; payments arrangements must be made prior to treatment beginning. Dr. Jeffrey Turner's office will file insurance for the patient at no additional charge, but if insurance benefits are not received within 60 days, the patient must pay the entire balance and obtain reimbursement from the Insurer. If the patient has secondary insurance, the responsible party will be liable for that portion at the time of service; the insurer will then reimburse the patient. If the account becomes past due, interest charges will accrue. If the patient's account is sent to a 3<sup>rd</sup> party for collections, the responsible party agrees to pay reasonable attorney's fees and any other legal fees and/or costs of collections.

I understand and agree to the above Financial Policies as they are stated above.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Today's date \_\_\_\_\_

## Acknowledgement of Receipt of Notice of Privacy Practices

*\*you may refuse to sign this acknowledgement\**

I, \_\_\_\_\_, have received a copy of University Park Family Dentistry Notice of Privacy Practices.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Today's date \_\_\_\_\_

### 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 acknowledgement

An emergency situation prevented us from obtaining acknowledgment

Other (Please specify) \_\_\_\_\_

# University Park Family Dentistry, LLC

16597 State Rd. 23 | South Bend IN, 46635 | 574-272-4441

## Written Financial Policy

Thank you for choosing University Park Family Dentistry, LLC. 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.

### Payment Options:

You can choose from:

- Mastercard, American Express, Discover Card, Cash or Check, Visa

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to completion of care for treatment plans of \$500 or more.

- NO INTEREST<sup>1</sup> Payment Plans<sup>2</sup> from CareCredit or CitiHealth

- o Allow you to pay over time with NO INTEREST<sup>1</sup>
- o Convenient, low monthly payment plans<sup>2</sup> also available
- o No annual fees or pre-payment penalties

Please note:

University Park Family Dentistry, LLC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of \$500 or more, a 20% deposit is required to secure your initial treatment appointment.

For 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.<sup>3</sup>

\_\_\_\_\_  
Initials

New patients are required to pay a minimum payment for their 1<sup>st</sup> visit, even if we are filing insurance.

\_\_\_\_\_  
Initials

A fee of \$45 is charged for patients who miss or cancel without 48-hour notice.

\_\_\_\_\_  
Initials

University Park Family Dentistry, LLC charges \$25 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)

<sup>1</sup>If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

<sup>2</sup>Subject to credit approval

<sup>3</sup>However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

**OVER**