New Patient Welcoming Packet

THIEL pediatric dentistry

Authorization to Treat

Financial Policy

Medical History

Notice of Privacy Practice

Notice of Privacy Practices Acknowledgement

you may refuse to sign this document.

I, _____ received a copy of this office's Notice of Privacy Practices.*

_____

patient name

_____

please print your name

_____

signature *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
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

_____

_____

_____

Notice of Privacy Practices

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 duty, 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 04/01/08, 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 policy 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 and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment

We may use/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 effect 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 to notify, as described in the Patient Rights sections 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 safety or the health of 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 officials 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 $0.75 for each page, $15.00 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 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 at info@thielpediatricdentistry.com.

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 you 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.

THIEL PEDIATRIC DENTISTRY
3755 CAPITAL OF TEXAS HWY SOUTH SUITE #292 AUSTIN, TX 78704
TEL (512) 892-0013 FAX (512) 892-3359

PATIENT NAME_____ NICKNAME _____ MALE ___ FEMALE ___ DOB_____

HOME ADDRESS _____CITY _____ZIP _____

PARENT/GUARDIAN NAME _____ DOB _____ DL# _____

WORK PHONE _____ CELL PHONE _____ HOME PHONE _____

EMAIL _____ (used to confirm appointments)

EMPLOYER _____ OCCUPATION _____ SS# _____

PARENT/GUARDIAN NAME _____ DOB _____DL# _____

WORK PHONE_____ CELL PHONE _____ HOME PHONE _____

HOME ADDRESS IF DIFFERENT _____

EMPLOYER _____ OCCUPATION _____ SS# _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ RELATION _____

HOME ADDRESS _____ PHONE _____

INSURANCE COVERAGE □ YES □ NO PERSON RESPONSIBLE FOR ACCOUNT _____

WHO REFERRED YOU TO THIS OFFICE? _____

MEDICAL HISTORY RECORD

Is your child being treated by a physician at this time? …… □ YES □ NO

Reason: _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? …… □ YES □ NO

List name, dose, frequency & date started: _____

Has your child ever had a reaction to or problem with an anesthetic? …… □ YES □ NO

Describe: _____

Has your child ever had a reaction or allergy to an antibiotic, sedative or other medication? …… □ YES □ NO

Describe: _____

Is your child allergic to LATEX? …… □ YES □ NO

Is your child allergic to any metals, acrylic, dye(s) or certain food(s)? …… □ YES □ NO

List: _____

Has your child or any siblings tested positive to any of the following: …… □ YES □ NO

___ Hepatitis A (infectious) ___ Hepatitis B (serum) ___ HIV (AIDS)

Has your child ever been hospitalized or have any health concerns that we should be aware of? …… □ YES □ NO

Diabetes ___ Kidney ___ Liver ____ Bleeding disorder ____ other _____

Describe: _____

MEDICAL HISTORY RECORD CONTINUED

Does your child have prolonged bleeding from cuts? ..... □ YES □ NO

Does your child have seizures? ..... □ YES □ NO

Describe: _____

Does your child have any history of heart trouble or a heart murmur? ..... □ YES □ NO

Describe: _____

Does your child have any breathing issues? ..... □ YES □ NO

If yes, please check all that apply: Asthma ___ RAD ___ RSV ___ Seasonal / allergy related _____

Does your child use an inhaler or nebulizer? ..... □ YES □ NO

Does your child have any other medical conditions (mental or physical) not listed above? ..... □ YES □ NO

Describe: _____

Physician: _____ Phone: _____

Date of last medical exam: _____

DENTAL HISTORY

Is this your child's first visit to the dentist? ..... □ YES □ NO

What is the name of the last dentist seen / family dentist? _____

Please list the date of the following:

Dental exam _____ topical fluoride treatment _____ x-rays _____

Has your child experienced an unfavorable reaction from previous dental or medical care? ..... □ YES □ NO

Describe: _____

Does your child have any mouth habits (thumb sucking, pacifier, etc.)?..... □ YES □ NO

Does your child have any dental problems or do you have any questions or concerns? □ YES □ NO

Describe: _____

POINTS OF INTEREST

Child's interests _____

_____

Child's favorite color _____

Pet's name(s) _____

Siblings treated here _____

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the dental office of any changes in medical status. I authorize my insurance company to give all necessary information required by Thiel Pediatric Dentistry in order to process any claims.

Signature: _____ Date: _____

(Parent / Guardian)

THIEL PEDIATRIC DENTISTRY

Dr. Gregory Thiel, DDS

AUTHORIZATION TO TREAT

_____

NAME OF PATIENT

I authorize Dr. Greg Thiel to perform a complete dental examination and take any necessary radiographs (x-rays). These are used to see and interpret signs of disease or potential problems that are not seen by direct visual exam. When scheduled for a routine check-up, will also include a dental prophylaxis (cleaning of the teeth) to remove any plaque, calculus (tartar), staining and fluoride treatment to strengthen enamel and help prevent development of decay.

_____

Signature Relationship Date

THIEL PEDIATRIC DENTISTRY

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we will accept cash, check, Visa, MasterCard, and American Express.
- **Your insurance is a contract between you and your insurance company.** As a courtesy, we will file your insurance claim for you if we are able to verify insurance coverage. At the time of service, we will collect any estimated portion that we think you will owe. We will require that you then assign benefits to the doctor, meaning that you agree to have the insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period of time, we will ask for payment from you. If we later receive a check from the insurance company, we will refund any over payment to you.
- We are contracted with Delta Dental (Premier), Blue Cross Blue Shield of Texas (DentaBlue), Humana PPO, Assurant PPO and Cigna PPO. If you are covered by one of these plans, we will bill them and will only require you to pay your estimated portion at the time of service. Any remaining balance would be due upon receipt of our statement.
- All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered" or over what they deem to be "usual and customary charges", you will be responsible for this amount. Payment is due upon receipt of a statement from our office. If payment is not made upon receipt of our statement, we will no longer file insurance for you and expect payment in full at time of service.
- We will look to the <u>adult accompanying</u> a minor for all services rendered to minor patients.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Patient Name_____Date_____

Responsible Party _____Date_____