

HEALTH INFORMATION

Personal Physician Name: _____

Personal Physician Address: _____

YES NO Have you been hospitalized within the past 2 years? For what? _____

YES NO Are currently being treated by a physician? For what? _____

YES NO Are you currently taking any medications or drugs? What? _____

YES NO Have you ever received counseling for excessive use of alcohol and/or prescription drugs? _____

YES NO Have you ever had a skin rash or other reaction to metal jewelry? _____

YES NO Are you allergic to any metals? What? _____

YES NO Do you bleed excessively upon injury? _____

YES NO Are you pregnant? _____

YES NO Do you have any medical allergies? _____

YES NO Are you allergic to LATEX? _____

MARK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR NOW HAVE

- A. Aids
- B. Arthritis
- C. Asthma
- D. Cancer
- E. Diabetes
- F. Artificial Joints
- G. Epilepsy
- H. Glaucoma
- I. Heart Murmur
- J. Heart Problem
- K. Hepatitis
- L. High Blood Pressure
- M. Jaundice
- N. Kidney Problems
- O. Low Blood Pressure
- P. Nervous Breakdown or Psychiatric Therapy
- Q. Rheumatic Fever
- R. Sexually Transmitted Diseases
- S. Stroke
- T. Tuberculosis
- U. Other Diseases

If you circled either J or F please describe condition: _____

Former Dentist and Date of last dental visit: _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Name: _____

Address: _____

Telephone: (Home) _____ (Work) _____

Signature

Date

Office Representative

Date

CONFIDENTIAL PATIENT INFORMATION – II (OFFICE USE ONLY)

Patient Name: _____ Initial Date: _____

Updated: _____

Updated: _____

Updated: _____

Updated: _____

Don Brown DDS FAGD LLC
510 Elk Ave Ste 2
Crested Butte, CO 81224
970-349-5577 Office 970-349-5578 Fax

CONFIDENTIAL PATIENT INFORMATION

Date: _____

PERSONAL INFORMATION

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Phone: _____ E-Mail: _____

Employer: _____ Work #: _____

Cell#: _____ Dr License#: _____

Referred By: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS#: _____

DOB: _____ Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ (work): _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS#: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co Address: _____

Employee: _____ Relationship: _____ SS#: _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

Patient/Parent/Guardian Signature

Date

DON BROWN DDS FAGD LLC

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 effective 4/14/2003, 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 significant change in our privacy practices, we will change this Notice and make the 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 obtain payment for services we provide to you.
PAYMENT: we may use and disclose you 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 or healthcare professionals, evaluation 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 a written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written 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's 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.

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 or 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 our 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 \$25.00 to copy your health information.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclose 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 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 location. **{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 your received this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTES

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 communicate with you by alternative locations, you may complain t us using the contact information listed at the end of the is Notice. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with address to file your complaint with the US 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 US Department of Health and Human Services.

CONTACT OFFICER: Missy Brown Phone: 970-349-5577

E-Mail: missyb.dbrowndds@gmail.com

ADDRESS: 510 Elk Ave Ste 2 Crested Butte, CO 81224

**Don Brown DDS FAGD LLC
510 Elk Ave Ste 2
Crested Butte, CO 81224
970-349-5577 Office 970-349-5578 Fax**

HIPAA PATIENT SIGNATURE

I have had full opportunity to read and consider the contents of DON BROWN DDS FAGD and ASSOCIATES Privacy Practices. I understand by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient Name

Date

**Parent or Guardian Signature
(If Patient is under the age of 18)**

DON BROWN DDS FAGD LLC
510 Elk Ave Ste 2
Crested Butte, CO 81224
Phone: 970-349-5577 Fax: 970-349-5568

FINANCIAL POLICY

Thank you for your loyalty to this practice. The reality of providing excellent dental care for our patients is achieved only with a partnership mindset by patients and ourselves. With this in mind, we will thank you by crediting your account here \$50.00 for each adult patient you refer to us (including your spouse).

A sound financial policy that is clearly understood by both patients and team members should result in no misunderstandings and will allow us to keep our fees lower than average.

We ask that you take a few moments to review our financial policy and ask us if you have any questions.

We are an “**Insurance Friendly Practice**” but do not accept all plans. (Some insurance companies place unacceptable limitations on our fees and thereby attempt to dictate treatment.

Types of Dental Insurance:

1. Fee for Service Insurance: Typically will require the patient to pay a deductible amount and the remainder will be covered on a percentage basis to be shared by the Insurance Providers and the Patient.
2. Contract Insurance: This insurance involves an agreement of fees between the dental office and Insurance Provider. This will result in the dental office accepting a lesser fee. The amount of discount fees will vary depending on the Insurance Provider. **We do not accept all of these plans.**

For patients with dental insurance: The estimated non-insured portion of your treatment will be expected at the time of the appointment; please, no exceptions unless prior arrangements have been made.

For patients without dental insurance: Full payment will be expected on the day of treatment; again, please no exceptions unless prior arrangements have been made.

Prior Arrangements to include:

Financing through Care Credit or In-House Financing (debt or credit card) *We accept post-dated checks*

A 5% courtesy will be applied for all patients paying all fees in full by cash or check.

A 2% courtesy will be applied for all guests paying all fees in full by credit card or debit card.

NOTE: Due to the discounted fees of “Contracted Insurance Plans” these courtesy cannot be offered.

We request to have either a debit or credit card authorization on file to satisfy any unpaid balances that is not covered by the insurance company.

We know you will understand and respect this financial policy that is designed to reduce our administrative efforts thereby allowing our Dental Team the time to personally serve you and keep fees lower.

Respectfully,

Our Dental Team

Accepted By:

Patient Name (Guarantor)

Date