LAKE BELTON
Family Dental
AND DENTURES

5408 W Adams Ave
Suite 102
Temple, TX 76502

We are committed to quality dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask and we will be happy to help.

Whom may we thank for referring you? _____

Name: _____

Date of Birth: ___/___/___ ☐ **Male** ☐ **Female** **Email Address:** _____

Social Security __ __ __-__ __ -__ __ __ __

Address: _____

(Street) (City/town) (State) (Zip Code)

Home Phone: (____) _____**Work:** (___) _____**Cell Phone:** (___) _____

Employer: _____

Guardian/Parent Name (if patient is minor) _____ Date of Birth_____

Driver License_____ Social Security_____

Emergency Contact _____ **Relationship** _____ **Phone**_____

Dental Insurance information

Do you have Dental Insurance? ☐ Yes ☐ No

If you have dental insurance, please complete section below: If no insurance ask about our Diamond Plan.

Dental Insurance

Company_____

Address_____

Subscriber Name_____

Subscriber ID# _____

Subscriber's Date of Birth ___/___/_____

Subscriber's Social Security Number _ _ _-_ _-_ _ _ _

Group/Policy #_____

Employer Name_____

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Medical and Dental History

Patient Name: _____ Date of Birth: _____

Why are you here today? _____

Are you having pain or discomfort at this time? ☐ Yes ☐ No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

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

_____

Has a dentist/physician ever told you that you need to take antibiotics before having dental treatment? ☐ Yes ☐ No

Do you use tobacco products (smoke, vape, or chew tobacco)? ☐ Yes ☐ No

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? ☐ Yes ☐ No

Do you have any allergies? If yes, please check all that apply: ☐ Yes ☐ No

☐ Penicillin ☐ Antibiotics ☐ Anesthetics ☐ Aspirin ☐ Latex ☐ Other: _____

What do you do to take care of your teeth and gums?

☐ Daily tooth brushing ☐ Daily flossing ☐ Electronic toothbrush ☐ Water jet device

Please mark any illnesses or conditions you may have or ever had:

Alcohol abuse/drug abuse	Diabetes	Rheumatic fever
Allergies to medicine(s)	Epilepsy	Shingles
Anemia or blood problems	Glaucoma	Sinus problems
Any heart ailments or problems	Osteoporosis	Stroke
Arthritis	Heart murmur	Seizures
Artificial joint	Hepatitis A, B, C	Thyroid problems
Asthma	High blood pressure	Tuberculosis
Blood transfusion	Heart surgery	Ulcer or colitis
Bruise easily	Immune system, HIV, AIDS, ARC	Sexually transmitted disease
Cancer or chemotherapy	Kidney problems	Sickle Cell Disease
Chronic cough	Liver problems	Yellow jaundice
Cold sores/fever blisters/herpes	Psychiatric care/emotional problems	

Do you have any other health conditions? ☐ Yes ☐ No

If yes, please list: _____

For women only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand that the above information is necessary to provide me with the best dental care in a safe and efficient matter. I have answered all questions truthfully.

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

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Acknowledgement of Notice of Privacy Practices Form

I have been given a copy of this Office's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

For Facility Use Only: ***Complete this section if you are unable to obtain a signature.***

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

   _____

   _____

Completed by	
Signature of Facility Representative	
Date	

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Our Financial Policy

Please read carefully and sign:

- **FULL PAYMENT IS DUE AND PAYABLE AT THE TIME OF SERVICE.**
- We accept **CASH, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CARE CREDIT** (NO INTEREST OR LOW INTEREST HEALTHCARE FINANCING PROGRAM). Any special arrangements must be discussed and approved by our billing manager prior to the start of treatment.
- **For patients with insurance,** we will gladly submit your insurance claims for you. Estimated deductibles and co-pays are due and payable at the time of service. We do not, however, submit for reimbursement from Flex Spending Accounts (FSA) or Health Savings accounts (HSA). The patient is responsible for paying our office for services and submitting their own reimbursement claims.
- **For Minor patients,** the adult accompanying the minor is responsible for full payment at the time of service.
- **All balances on billing statements are due and payable upon receipt.** You are responsible for all fees for treatment rendered regardless of your status as an active or inactive patient.
- **Delinquent accounts:** Patients with delinquent accounts will be required to make full payment on account prior to making appointments for any additional treatment. A late fee of $30 will be applied to all accounts overdue more than 60 days from the date of service. Interest at the rate of 1% per month will be applied to such accounts. You are responsible for costs associated with the collections of a delinquent account including reasonable attorney fees and court costs. The doctor is authorized to disclose portions of the patient's dental record to the extent necessary to determine liability for payment and to obtain reimbursement. Furthermore, you may dismissed from the practice.
- **Cancellation/missed appointments:** We require 24 hour advanced notice for any cancellations. We do not accept cancellation via our voice mail or email systems, you must speak with a staff member. A $50 broken appointment will be assessed if proper notification is not given. Frequent missed or cancelled appointments can lead to dismissal from the practice.

Our Financial Policy cont.

INSURANCE: It is our pleasure to assist you in maximizing your insurance benefits and as a courtesy, we will file your claims. We will **estimate** your patient portion not covered by insurance, and this amount will be due and payable at the time of service. As it is impossible to know the details of every insurance policy, **our estimate may differ from the actual coverage**. Our practice is committed to providing the best treatment for our patients and we set our fees based on the quality of treatment we provide. The insurance is a contract between you and your insurance company. You are ultimately responsible for the fees on the account regardless of insurance coverage. Insurance is not a substitute for payment.

FURTHERMORE:

- You must provide our office with complete and accurate billing information prior to treatment, including your current insurance card. If we cannot verify you policy, you will be asked to make full payment.
- We want you to know and understand you insurance coverage. If you have any questions please ask us.
- You are responsible for all charges not covered by your insurance. This includes co-payments, deductibles, and fees for non-covered services. If after 60 days your claim remains unpaid by your insurance company you will become responsible for the amount. If the claim is paid, you will be refunded the claim amount.
- You authorize Dr. Stephens and any associates of Lake Belton Family Dental and Dentures to submit claims and assign benefits to the billing provider. Assignment of benefits will remain in effect until revoked in writing. A photocopy of this assignment is considered as valid as an original.

If you have any questions regarding our financial policy please do not hesitate to ask.

Patient Signature or parent/Guardian_____

Printed Name_____ **Date** _____

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Appointments

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us, please be on time, we reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least a 24 hour notice so that we may work with you to find another date that fits your schedule. We allow one missed appointment as a courtesy, any additional missed appointments we may charge a $50 fee for the inconvenience.

Please note: Patients who miss Saturday appointments without prior notice, will no longer be scheduled on a Saturday.

Confirmations

We use emails, phone calls, and text messages as appointment reminders and important messages. You will be sent and initial email or text to opt in to this reminder system.

Authorization and Consent

Assignment of Insurance Benefits (please initial):

___ I authorize and request my insurance company to pay my benefits directly to Lake Belton Family Dental and Dentures.

Notice of Privacy Practices

___ I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.

___ I understand that I may ask questions that I might have regarding this notice.

General Consent

___ I authorize Dr. Stephens and any associates of Lake Belton Family Dental and Dentures to take photographs/x-rays of me to help better understand my current dental condition and possible treatment options.

___ I understand that recording devices of any kind (audio or visual) are **prohibited** without both party consent

___ I understand and will comply with office **Appointment Policy**.

___ I understand and will comply with the office **Financial Policy**.

___ I understand and agree to the **General Consent to Treatment**.

___ I understand and agree to the **Notice of Privacy Practices**.

X_____ _____

Signature of patient, parent, or guardian **Date**

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This Facility is required by law to provide you with this Notice of Privacy Practices (hereafter: "Notice") so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact our HIPAA Compliance Officer.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to our Facility, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate health professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

For Treatment
We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to Facility personnel who are involved in taking care of you at our Facility. Different departments of a Facility also may share health information about you in order to coordinate your care. We may also disclose health information about you to people outside the Facility who may be involved in your care after you leave a Facility. This may include family members, or visiting nurses to provide care in your home.

For Payment
We may use and disclose health information about you so that the treatment and services you receive at a Facility may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations
We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all residents receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols.

We may also combine health information about many residents to help determine what additional services we should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs.

Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the Facility including resolution of internal grievances and customer service.

In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of residents.

We may disclose your age, birth date and general information about you in the Facility newsletter, on activities calendars, and to entities in the community that wish to acknowledge your birthday or commemorate your achievements on special occasions. If you are receiving therapy services, we may post your photograph and general information about your progress.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

Business Associates
There may be some services provided in our Facility through contracts with business associates. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Treatment Alternatives
We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services and Reminders
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care.
Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As Required By Law
We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety
We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

Organ and Tissue Donation
If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

Research
Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all residents who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with residents' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.

Workers' Compensation
We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

OTHER DISCLOSURES
Reporting Federal and state laws may require or permit the Facility to disclose certain health information related to the following:

Public Health Risks

We may disclose health information about you for public health purposes, including:

- Prevention or control of disease, injury or disability
- Reporting births and deaths
- Reporting child abuse or neglect
- Reporting reactions to medications or problems with products
- Notifying people of recalls of products
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease
- Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities
We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings
If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Reporting Abuse, Neglect or Domestic Violence
Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect or domestic violence.

Law Enforcement
We may disclose health information when requested by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Correctional Institution
Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
Although your health record is the property of the Facility, the information belongs to you. You have the following rights regarding your health information:

Right to Inspect and Copy
With some exceptions, you have the right to review and copy your health information.

You must submit your request in writing our HIPAA Compliance Officer.

We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend
If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Facility.

You must submit your request in writing to our HIPAA Compliance Officer.

In addition, you must provide a reason for your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the Facility; or
- Is accurate and complete.

Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

You must submit your request in writing to our HIPAA Compliance Officer. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You must submit your request in writing to our HIPAA Compliance Officer.

In your request, you must tell us:

1. what information you want to limit
2. whether you want to limit our use, disclosure or both
3. to whom you want the limits to apply, for example, disclosures to your spouse

Right to Request Alternate Communications
You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

You must submit your request in writing to our HIPAA Compliance Officer.

We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Facility administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Facility, contact our HIPAA Compliance Officer.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

CONTACT US

If you wish to contact us regarding the terms in this Notice, please contact:

Name: MaryBeth Massey (HIPPA compliance Officer)

Phone Number: 254-231-4946

Email: info@lakebeltonfamilydentalanddentures.com