PALMER FAMILY DENTISTRY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is used to document that you received a copy of our Notice of Privacy Practices or to document our good faith effort to obtain your acknowledgement. Our Notice explains how our office uses and discloses your Protected Health Information. You have the right to have a copy of and to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment, and healthcare operations, uses and disclosures we may make of your protected health information. The Notice also details other important uses regarding your protected health information. A copy of our Notice accompanies this Consent.

Name: _____ Patient Number_____

Address: _____

Phone Numbers Home: _____ Work_____ Cell _____

I, _____, have received a copy of Palmer Family Dentistry's Notice of Privacy Practices.

{Date}_____ **You May Refuse to Sign This Acknowledgement**

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)

CONSENT FOR OTHER USE AND DISCLOSURE OF PROTECTED INFORMATION

Purpose of additional consent: By completing this section of the form, you are giving permission for use and disclosure other than for treatment, payment activities, and healthcare operations. It is our policy to use and disclose your Protected Health Information for Treatment, Payment and Healthcare Operation. However under certain situations it may be necessary for us or convenient for you to allow us to disclose information in other situations. The following is a list of activities that may apply to you**. Please indicate your permission by checking the box next to the activity.**

☐ Permission to leave detailed appointment reminders at the home, work or cell numbers designated by the patient.

☐ Permission to leave appointment reminders with secretaries or contact person or voice mail in the work place.

☐ Notifying patients via e-mail of dental appointments.

☐ Calling or notifying a spouse or other family member as to an appointment of another family member or spouse.

☐ Releasing health or payment information of a minor child to a ☐ non-custodial parent, ☐ stepparent or ☐ grandparent.

☐ Calling or notifying a ☐ non-custodial parent, ☐ stepparent or ☐ grandparent as to dental appointments of a minor child.

Other situations in which you give us permission to disclose individually identifiable protected information.

_____

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

SIGNATURE

I, _____, have read the contents of this form and I have received a copy of your Notice of Privacy Practices. I understand that, by signing this section of this form, I am giving my consent to your use and disclosure in the situations I have designated above.

Signature: _____ Date: _____

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Mary Eldridge
Telephone: 316-524-8661
Address: 1401 W. Grand, Haysville, KS 67233

REVOCATION OF CONSENT (only sign here if you are revoking your additional consent in the situations listed above)

You have the right to revoke this consent. I revoke my Consent for your use and disclosure of my protected health information for the situations I specifically designated above. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

PALMER FAMILY DENTISTRY

PAYMENT POLICY

Scott V. Palmer, D.D.S., P.A.

Charles Jordan, D.D.S.

Toby Lee, D.D.S.

We are committed to providing you with the best possible dental care. If you have dental insurance, we will help you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payments for services are due ***at the time services are provided*** **AND ARE ESTIMATES ONLY.** We accept **cash**, **checks** (which we process electronically and are verified through telecheck), **Master Card, American Express, Discover** or **Visa.** We also provide financing through **Care Credit** (with approved credit). If you would like more information about financing, please ask our front desk staff to help you.

Please remember these important factors:

1. Your insurance is a contract between you, your insurance company and possibly your employer.
2. We file insurance as a courtesy to our patients.
3. Not all services are a covered benefit in all contracts.
4. If you have questions about your benefits call your insurance company.

We must emphasize that as your dental care providers, our relationship is with you.
While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 60 days, the charges will be the patient's responsibility to pay.

**If the need arises to have the balance on your account collected by an outside agency, YOU will be responsible for all collection and/or legal fees.

THERE WILL BE A $25.00 FEE FOR ANY APPOINTMENTS NOT CANCELLED WITH 24 HOURS NOTICE.

Patient signature_____ Date: _____

Guardian signature_____ Date:_____

PALMER FAMILY DENTISTRY

WELCOME

Patient Information

Date: _____

Name_____ Birth Date _____
First MI Last

SS#_____ Driver's License# _____

Home Ph# _____Cell Ph# _____ Email _____

Address_____ City _____St ____ Zip_____

____ Minor ____Single ____Married ____Separated ____Divorced ____Widowed

Employer _____ Work ph# _____

If Student, Name of School/College _____

Whom May We Thank for Referring You? _____

Emergency contact in case of an emergency _____ **Ph#** _____

If patient is a minor child - Who is responsible for payment

Name_____ Birth Date _____
First MI Last

SS#_____ Home Ph# _____ Cell Ph# _____

Address_____ City _____St ____ Zip_____

Employer _____ Work ph# _____

Insurance information:

Primary Insurance: _____

Employer Name _____ Group#_____
Relationship

Name of Insured _____ to Patient _____
First MI Last

Birth Date _____ SS# _____ Policy ID# _____

Secondary Insurance: _____

Employer Name _____ Group#_____
Relationship

Name of Insured _____ to Patient _____
First MI Last

Birth Date _____ SS# _____ Policy ID# _____

PALMER FAMILY DENTISTY

PATIENT NAME _____ DATE _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Exam _____

List all medications you are currently taking: _____

_____

_____

Are you **allergic** or have you reacted adversely to any of the following:

Please circle any and all that apply:

Aspirin Penicillin Codeine Erythromycin Sulfa Drugs Other Antibiotics

Latex Ibuprofen Tetracycline Barbiturates Tylenol/Acetaminophen

Nitrous Oxide Local Anesthesia

Have you had or have at present any of the following conditions?

Please circle any and all that apply:

AIDS or HIV	Cancer	Hay Fever/Allergies	Kidney Disease	Rheumatic Fever
Anemia	Cardiac Pacemaker	Heart Disease	Leukemia	Sexually Transmitted Disease
Angina	Chest Pains	Heart Murmur	Liver Disease	Stomach troubles/Ulcers
Arthritis	Diabetes	Heart Surgery	Low Blood Pressure	Stroke
Artificial Joints	Emphysema	Hepatitis/Jaundice	Mitral Valve Prolapse	Thyroid Problem
Asthma	Epilepsy/Seizures	High Blood Pressure	Radiation therapy	Tuberculosis
Autism	Fainting/Seizures	Joint Replacement/Implant	Respiratory Problems	

Please circle one:

Yes No Have you been hospitalized during the past two years?

Yes No Have you been asked by your medical doctor to pre-medicate before any dental treatment.

Yes No Do you have any disease, condition, or problems not listed?

If so, please list_____.

Yes No Do you smoke or use tobacco?

Yes No WOMEN ONLY: Are you Pregnant? If pregnant, when is your due date _____

Authorization or Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third payors and/or health practitioners.

Patient/or Guardian Signature_____ Date _____

Dentist's Signature _____ *Date* _____