



Welcome



Gentle Dental Care
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The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1. About You

Today's Date: _____

Name: _____

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ Social Security #: _____

Home Address: _____

City, State, Zip: _____

Single Married Divorced Widowed Separated

Home #: _____ Pager/Cell#: _____

WK#: _____ Ext. _____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are the best times to reach you? _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

2. Spouse Information

Their Name: _____

Employer: _____

WK#: _____ Ext. _____ SS#: _____

Birthdate: _____ DL#: _____

Person Responsible for Account: _____

WK#: _____ Ext. _____ HM#: _____

Billing Address: _____

Relationship: _____ SS#: _____

Employer: _____ DL#: _____

3. Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

WK#: _____ HM#: _____

4. Medical History

Do you have a personal physician? No Yes

Physician's Name: _____

Phone#: _____ Date of last visit: _____

CONTINUED ON BACK OF FORM

4. Medical History continued

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? No Yes

Please Explain: _____

Are you taking any prescription/over-the-counter drugs? No Yes

Please list each one _____

For Women Are you taking birth control pills? No Yes

Are you pregnant? No Yes Week # _____

Are you nursing? No Yes

Have you ever had any of the following diseases or medical problems?

- | | |
|-----------------------------|---------------------------------------|
| Y N Heart Attack/Stroke | Y N Psychiatric Problems |
| Y N Congenital Heart Defect | Y N Epilepsy/Seizures/Fainting Spells |
| Y N Heart Surgery | Y N Diabetes |
| Y N Mitral Valve Prolapse | Y N Drug/Alcohol Abuse |
| Y N Heart Murmur | Y N Venereal Disease |
| Y N Rheumatic Fever | Y N Hemophilia/Abnormal Bleeding |
| Y N HIV+/AIDS | Y N Ulcers/Colitis |
| Y N Kidney Problems | Y N Cancer/Chemotherapy |
| Y N Artificial Bones/Joints | Y N Radiation Treatment |
| Y N Artificial Valves | Y N Asthma |
| Y N Sinus Problems | Y N Arthritis |
| Y N High Blood Pressure | Y N Difficulty Breathing |
| Y N Low Blood Pressure | Y N Hospitalized for any reason |
| Y N Severe/Freq. Headaches | Y N Hepatitis/Liver Problems |
| Y N Glaucoma | Y N Blood Transfusion |

Please list any serious medical condition(s) that you have ever had:

Do you use chewing tobacco? Y N Currently _____ How Long _____

Have you ever smoked? Y N Currently _____ How Long _____ Packs a Day _____

Are you allergic to any of the following drugs?

- | | | |
|------------------|------------------------|-----------|
| Y N Penicillin | Y N Tetracycline | Y N Latex |
| Y N Aspirin | Y N Dental Anesthetics | Y N Other |
| Y N Erythromycin | Y N Codeine | |

Please list any other drugs that you are allergic to: _____

I authorize the dental staff to perform the dental services for me where appropriate, including, but not limited to; full mouth exam radiographs, (x-rays), cleaning, fluoride treatment and sealants on molars.

Patient Signature and/or Parent/Guardian when Patient is a minor

Date

How did you hear about our office?

_____ Insurance Plan/Provider

_____ Welcome Wagon

_____ Yellow Pages

5. Dental History

Why have you come to the dentist today? _____

Are you currently in pain? No Yes

Have you ever had a serious/difficult problem associated with any previous dental work? No Yes

Do you now or have you ever experienced pain/discomfort in you jaw joint (TMJ/TMD)? No Yes

Your current dental health is Good Fair Poor

Do you like the appearance of you smile? No Yes

If you could change anything about it, what would you change?

Do your gums ever bleed? No Yes

How many times a day do you brush? _____ a week do you floss? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. *I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.*

Signature

Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Gentle Dental Care 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.

For purposes of this notice “us” and “our” refers to Gentle Dental Care and “you” or “your” refers to our patients (or their legal representatives as determined by us in accordance with Idaho informed consent law). When you receive health-care services from us, we will obtain access to your medical information (e.g., your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

Idaho law and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) require us to maintain the confidentiality of all your health-care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally (“PHI” or Protected Health Information). HIPAA is a federal law that gives you significant new rights to understand and control how your health information is used. HIPAA and Idaho law provide penalties for covered entities and records owners, respectively, that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with this Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak to our privacy officer, Laura Kellar at 466-3597.

Gentle Dental Care employees follow the policies and procedures set forth in this notice. We may provide you with the name of another health-care provider outside Gentle Dental Care for you to consult with by telephone. If we do so, that provider will follow the policies and procedures set forth in this notice or those established for his or her practice, so long as they substantially conform to those of Gentle Dental Care.

This Notice of Privacy Practices describes how we may use and disclose your protected-health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy practices by accessing our website: www.gentledental.biz, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

1. Uses and Disclosure of Protected Health Information Based Upon Your written Consent.

Under the law, we must have your signature on a written, dated Consent form and/or an Authorization form (not an Acknowledgment form) before we will use and disclose your PHI for certain purposes as detailed in the rules below.

You will be asked by your dentist to sign an acknowledgement form that you have had an opportunity to review this notice. Your dentist will use or disclose your protected health information as described in this Section 1.

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the dentist’s practice.

Following are examples of the types of uses and disclosures of your protected health care information that the dentist’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office upon acknowledgement that this information has been made available to you.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to other dentists who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to another dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another dentist or health care provider (e.g. a specialist or laboratory) who, at the request of your dentist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your dentist.

Payment: Your protected health information will be used, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a course of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of the dentist practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to dental assistant extern students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact and request that these fundraising materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your dentist, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, at any time, in writing, except to the extent that your dentist or the dentist’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your dentist may, using professional judgement, determine whether the disclosure is in your best interest. In this case only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personally representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief effort and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your dentist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your dentist or another dentist in the practice is required by law to treat you and the dentist has attempted to obtain your consent but is unable to obtain consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your dentist or another dentist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the dentist determines, using professional judgement, that you intend to consent to use or disclose under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran's Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information if it is necessary to authorized federal officials for conducting national security and intelligence activities, including for the provision of protected services to the President or others legally authorized.

Worker's Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your dentist created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information: This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical billing records and any other records that your dentist and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have any questions about access to your medical record.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction request and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your dentist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your dentist.

You have the right to request to receive confidential communications from us by alternative means at an alternative location: We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your dentist amend your protected health information: This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny you request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical records.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Special Rules: Notwithstanding anything else contained in this Notice, only in accordance with applicable law, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state or local law;
- When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons;
- When necessary for public health reasons (e.g., prevention or control of disease, injury or disability; reporting information such as adverse reactions to anesthesia; ineffective or dangerous medications or products; suspected abuse, neglect or exploitation of children, disabled adults or the elderly; or domestic violence);
- For federal or state government health-care oversight activities (e.g., civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.);
- For judicial and administrative proceedings and law enforcement purposes (e.g., in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death);
- For workers’ compensation purposes (e.g., we may disclose your PHI if you have claimed health benefits for a work-related injury or illness);
- For intelligence, counterintelligence, or other national security purposes (e.g., Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you);

- For organ and tissue donation (e.g., if you are an organ donor we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation);
- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (e.g., if the researcher will have access to your PHI because they are involved in your clinical care, we will ask you to sign an Authorization);
- To create a collection of information that is “de-identified” (e.g., it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you);
- To family members, friends and others, but only if you verbally give permission; we give you an opportunity to object and you do not; we reasonably assume, based on our professional judgement and the surrounding circumstances, that you do not object (e.g., you bring someone with you into the clinic during treatment or when we are discussing your PHI); we reasonable infer that it is in your best interest (e.g., to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (e.g., your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person’s care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgement and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed.

Minimum Necessary Rule: No one in Gentle Dental Care

will use or access your PHI unless it is *necessary* to do their jobs. Also, we disclose to others outside our staff only as much of your PHI as is necessary to accomplish the recipient’s lawful purposes. For example, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and any one else you list on a Consent or Authorization to receive a copy of your records;
- To health-care providers for treatment purposes (e.g., making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record);
- To the U.S. Department of Health and Human Services (e.g., in connection with a HIPAA complaint);
- To others as required under federal or Idaho law;
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (e.g., clerks who copy records need access to your entire medical record)

In accordance with the law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requester’s purpose. Our privacy officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, the Plan’s Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed;
- The number of individual or entities to whom the information is being disclosed;
- The importance of the use or disclosure;
- The likelihood of further disclosure;
- Whether the same result could be achieved with de-identified information;
- The technology available to protect confidentiality of the information; and
- The cost to implement administrative, technical and security procedures to protect confidentiality. If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requester to document why this is needed, retain that documentation, and make it available to you upon request.

Incidental Disclosure Rule: We will take the reasonable administrative, technical, and security safeguards to ensure the privacy of your PHI when we use or disclose it (e.g., we require doctors, externs, and staff to talk softly when discussing PHI with you, we use computer passwords and change them periodically [e.g., when an employee leaves us], we allow access to areas where PHI is stored or filed on when we are present to supervise and prevent unauthorized access.)

Authorization Rule: We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on a specifically worded, written Authorization form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it on our Authorization form, which is separate from any Consent or Acknowledgement we may have obtained from you. We will not condition treatment on whether you sign the Authorization (or not).

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the right to get, at any time, a paper copy of this Notice by asking our privacy officer. Also, you have the following additional rights regarding PHI we maintain about you:

To inspect and Copy: You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our privacy officer on our Request to Inspect, Copy or Summarize form. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our privacy officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impracticable) or ask us to prepare a summary in lieu of the copies. We will charge you a fee not to exceed Idaho law to recover our costs (\$0.25 per copied page and \$1.00 per hour for staff time to copy health information; or...\$25.00 for digital format and \$1.00 per hour for staff to put the information on a CD or DVD or other digital format, and including first-class postage, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies or summary on payment of your outstanding balance for professional services (if you have one), but we may condition release of the copies or summary on payment of the copying fees. We will respond to requests in a timely manner, without delay for legal review, in less than thirty days if submitted in writing on our form or otherwise, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (e.g., we do not have the PHI; it came from a confidential source; etc). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed health-care professional who is not affiliated with us, we will ensure a Business Associate agreement is executed that prevents re-disclosure of your PHI without your consent by the outside professional.

To Request Amendment/Correction: If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a Request for Amendment/Correction form to our privacy officer. We normally will act on your request within 60 days from receipt, but we may extend our response time (within the 60-day period) no more than once and by no more than 30 days, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within five business days to the persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (e.g., it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed [and the entity that did can be contacted], it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within five business days) tell you why and how to file a complaint with us if you disagree, that you may submit a written disagreement with out denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosures of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures: You may ask us for a list of those who got your PHI from us by submitting a Request for an Accounting of Disclosures form to us. The list will not cover some disclosures (e.g., PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (e.g., paper, fax, or digital) and the time period you want us to cover, which may be up to but not more than the last six years (excluding dates before April 14, 2003).

To Request Restrictions: You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written Request for Restrictions on Use/Disclosure form to us (e.g., you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (e.g., we are required by law to use or disclose your PHI in a manner that you want restricted; you signed an Authorization form which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

Faxing and E-mailing Rule: When you request us to fax or e-mail your PHI as an alternative communication and we agree to do so, we may fax or e-mail super-confidential information; we will not use fax or e-mail for emergency communication without knowing that the recipient is expecting the message; have only our privacy officer, or treating dental hygienist, or dentist, fax or e-mail your PHI; have our

privacy officer confirm that the fax number or e-mail address is correct before sending the message and ensure that the intended recipient has sole access to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page); and attach an appropriate privacy notice to the message.

Inactive Patient Records: We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighth birthday). We will do so only in accordance with the law (e.g., in a confidential manner, with a Business Associate agreement prohibiting re-disclosure if necessary).

Collections and Marketing: If we use or disclose your PHI for marketing (i.e., communications that encourage recipients to purchase or use a product or service) or collections purposes, we will do so only in accordance with the law.

To Request Alternative Communications: You may ask us to communicate with you in a different way or at a different place by submitting a written Request for Alternative Communication form to us. We will not ask you why and we will accommodate all reasonable requests (including, e.g., to send appointment reminds in closed envelopes rather than by postcards, to send you PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payments will be made if we communicate with you as you request.

To Complain or Get More Information: We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (e.g., you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

**The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(877) 696-6775 (toll free)**

Or submit a written Complaint form to us at the following address:

**Gentle Dental Care
4411 E. Flamingo Rd
Nampa, Id 83687
(208) 466-3597**

You may get your complaint form by calling our privacy officer:

**Chris Granere – Financial Coordinator
(208) 466-3597**

These privacy practices will be effective April 14, 2003, and will remain in effect until we replace them as specified above.

**Gentle Dental Care
Notice of privacy Practices**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

1. Please print this page.
2. Fill out appropriate fields.
3. Bring to first appointment.

I, _____, have read Gentle Dental Cares Notice
Please Print Patient Name

of privacy Practices.

Please check one of the following:

- I have been provided with a copy of the Gentle Dental Care Notice of Privacy Practices and I have chosen to retain a written copy.
- I have been provided with a copy of the Gentle Dental Care Notice of Privacy Practices and I have chosen **NOT** to retain a written copy.

Patient Signature _____ Date: ____/____/____

Patient's Representative's Signature _____ Date: ____/____/____

Relationship to patient _____

For Office Use Only

As privacy officer, I attempted to obtain the (____patient's) (____representative's) signature on this acknowledgement.

- Patient signed
- Patient's representative signed
- Patient refused to sign
- Patient's representative refused to sign
- I could not communicate with the patient
- I could not communicate with the patient's representative
- It was emergency treatment
- Other (Please Specify) _____

Privacy officer's signature _____ Date: ____/____/____



TREATMENT PLANS AND INSURANCE ESTIMATES

Gentle Dental Care provides a treatment plan and a financial estimate at check out. I understand that this is strictly an estimate, and that my treatment may change during the procedure due to the extent of the decay, patient behavior, or other unexpected situations.

Patient Signature

Date



4411 E. Flamingo Rd., Nampa, Idaho 83687 (208)466-3597
1601 12th Ave. Rd., Nampa, Idaho 83686 (208)467-9690

PATIENT FINANCIAL OPTIONS

Our office is committed to providing you with exceptional quality dental care at affordable fees with comfortable financial options. It is our intent to ensure that you have every opportunity to wisely invest in a smile that will be beautiful, healthy, and functional. For this reason, we have developed the following financial options, which we believe will be of great assistance to you:

1. **PAYMENT IN FULL:** For non-insurance patients, **PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE.** We accept cash, personal checks, Visa, Master Card, Discover, or American Express. Insurance patients are required to pay the portion of the bill we anticipate the insurance will not cover.
2. **CARE CREDIT:** Receive up to 12 months interest free by applying for this medical credit card.

DENTAL INSURANCE: As a courtesy to you, we will bill your insurance company. **Remember, your insurance policy is a contract between you and your insurance carrier. We are not party to the contract.** Please be aware that some, and perhaps all of the services provided may be non-covered. To avoid misunderstandings with regard to your benefits we suggest that you review your policy manual, or call the telephone number located on the back of your dental insurance card for an overview of benefits. Our financial coordinator at the front desk can also be of assistance. Remember, this office cannot accept responsibility for collecting your insurance claim for you or negotiating a settlement on a disputed claim. It is understood that you will be responsible for payment in full of all claims submitted to your insurance company that remain unpaid within 45 days from the date of treatment. The remaining balance owing on your account after your insurance settles is due in full within 10 days of the insurance payment, unless prior arrangements have been made.

FINANCE CHARGE: A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to the account. The finance charge will be computed at the rate of one point five percent (1.5%) per month or an annual percentage rate of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the “overdue balance” on your account. The “overdue balance” of your account is calculated by taking the balance owed sixty (60) days age, and then subtracting any payments or credits applied to the account during that time.

CREDIT HISTORY: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

REQUIRED PAYMENTS: Any co-payments or deductibles required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

RETURNED CHECKS: There is a fee (currently \$25) for any checks returned by the bank.

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a \$25 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Over please

DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Canyon County, Idaho.

TRANSFERRING OF RECORDS: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

WAIVER OF CONFIDENTIALITY: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

WORKERS COMPENSATION: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

PERSONAL INJURY: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

RELEASE OF BENEFITS AND INFORMATION: I authorize my insurance benefits to be paid directly to the doctor. I also authorize the doctor or insurance company to release any information required for this claim.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

NAME: _____

DATE: _____