SOUTHERN SHORES
DENTAL

PATIENT INFORMATION

◯Mr. ◯Mrs. ◯Miss _____ _____ _____ _____
◯Dr. ◯Ms. *Last Name* *First Name* *MI* *Preferred*

Date of Birth _____/_____/_____ Age _____ SSN _____ Marital Status: ◯ M ◯ S ◯ D ◯ Other

Street Address_____City_____State_____Zip_____

Email_____ Cell #_____ Home#_____

Employer _____ Title _____ Work Phone _____

Whom may we thank for referring you to our Practice?_____

GUARANTOR INFORMATION *(PLEASE COMPLETE THIS SECTION, ONLY IF THE PATIENT IS A MINOR)*

◯Mr. ◯Mrs. ◯Miss _____ _____ _____ _____
◯Dr. ◯Ms. *Last Name* *First Name* *MI* *Preferred*

Relationship to Patient: _____ Date of Birth: _____/_____/_____ SSN: _____

Street Address_____City_____State_____Zip_____

Email_____ Cell #_____ Home#_____

Employer _____ Title _____ Work Phone _____

INSURANCE INFORMATION *(Please complete the following information as it pertains to the policy holder/subscriber)*

◯Mr. ◯Mrs. ◯Miss _____ _____ _____ _____/_____/_____
◯Dr. ◯Ms. *Last Name* *First Name* *MI* *BIRTHDATE*

EMPLOYER _____ GROUP # _____ ID#/SSN _____

INSURANCE COMPANY _____ TELEPHONE _____

INSURANCE AUTHORIZATION:

I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF PATIENT IS A MINOR) DATE

(803) 359-6143
110 Charter Oak Road • Lexington, SC 29072
southernshoresdental.com

MEDICAL HISTORY INFORMATION

DO YOU NOW, OR HAVE YOU EVER, HAD ANY OF THE FOLLOWING? ***(PLEASE CHECK ALL THAT APPLY)***

_____AIDS/HIV	_____DIABETES	_____HIGH BLOOD PRESSURE	_____RESPIRATORY PROBLEMS
_____ANEMIA	_____EPILEPSY	_____HEPATITIS (___A___B___C)	_____RHUEMATIC FEVER
_____ARTHRITIS	_____EXCESS BLEEDING	_____KIDNEY DISEASE	_____RHEUMATISM
_____ARTIFICIAL JOINTS	_____FAINTING	_____LIVER DISEASE	_____SINUS PROBLEMS
_____ASTHMA	_____GLAUCOMA	_____MENTAL DISORDERS	_____STENT
_____BETA BLOCKER	_____GROWTHS	_____MITRAL VALVE PROLAPSE	_____STROKE
_____BLOOD DISEASE	_____HAY FEVER	_____NERVOUS DISORDERS	_____TUBERCULOSIS
_____BLOOD THINNERS	_____HEAD INJURIES	_____PACEMAKER	_____TUMORS
_____CANCER	_____HEART DISEASE	_____PREDNISONE	_____ULCERS
_____COLD SORES	_____HEART MURMUR	_____RADIATION TREATMENT	_____VENEREAL DISEASE

Women Only:
Are you pregnant? ◯ YES ◯ NO ***Are you taking birth control medication?*** ◯ YES ◯ NO ***Are you currently breastfeeding?*** ◯ YES ◯ NO

Are you allergic to (ie: itching, rash, swelling of hands, feet or eyes) penicillin, latex, aspirin, codeine, or any other drugs or medicines? ◯ YES ◯ NO
*If yes, please explain:*_____

Do you have any disease, condition or problem not listed? ◯ YES ◯ NO
*If yes, please explain:*_____

Are you currently taking any medications? ◯ YES ◯ NO
*If yes, please list here:*_____

Have you been admitted to a hospital or received emergency care during the past two years? ◯ YES ◯ NO
If yes, please explain: _____

Date of last dental visit? _____ Reason **for visit?** _____

Have you ever had any complications following dental treatment? ◯ YES ◯ NO
*If yes, please explain:*_____

Do you have any health/dental related problems that need further clarification? ◯ YES ◯ NO
*If yes, please explain:*_____

Name of physician_____**Telephone**_____

CONSENT FOR SERVICES:

I HEREBY AUTHORIZE THE DOCTOR TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION, AND THERAPY THAT MAY BE INDICATED IN CONNECTION WITH THE DENTAL CARE OF THE PATIENT ABOVE AND FURTHER AUTHORIZE AND CONSENT THAT THE DOCTOR CHOOSES AND EMPLOYS SUCH ASSISTANCE AS HE/SHE DEEMS FIT. I ALSO UNDERSTAND THAT PRIOR TO TREATMENT, FULL EXPLANATION OF THE PROCEDURE(S) INVOLVED WILL BE GIVEN BY THE DOCTOR AND/OR TEAM. I AGREE TO PAY FOR ALL SERVICES RENDERED BY THIS OFFICE.

_____ _____
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF PATIENT IS A MINOR) DATE

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process your Primary Dental insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring your Dental Insurance card or proof of insurance at each appointment. We will provide you with a blank ADA form for you to file with your secondary insurance carrier if applicable, as our office does not file secondary claims.

Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Estimates given are not a guarantee of payment. It is the patient's responsibility to be aware of their individual policies maximums and limitations. Our practice accepts cash, personal checks, MasterCard, Visa and Discover. Third party, extended payment financing is available upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees.

Our practice requires a 48-hour notice for appointment cancellations. A broken appointment charge may apply.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

AUTHORIZATION – COMPOUND TREATMENT AND SOCIAL MEDIA

This authorization form permits **Southern Shores Dental** to use or disclose protected health information listed in the Description section below to the Entity and/or Person listed in the Receiving Entity section for the following patient:

Patient Name: _____ Date of Birth: _____

ENTITY TO RECEIVE INFORMATION: Check each person/entity that you approve to receive information.	**DESCRIPTION OF INFORMATION TO BE RELEASED:** Check each that can be given to person/entity on the left in the same section.
Authorization to contact me (select below) ◯ PERSONAL VOICEMAIL (HOME/CELL) ◯ PERSONAL TEXT MESSAGES ◯ BUSINESS VOICEMAIL ◯ PERSONAL UNENCRYPTED EMAIL ADDRESS ◯ **ALL OF THE ABOVE**	◯ APPOINTMENT/ABSENTEE INFORMATION ◯ FINANCIAL/BILLING INFORMATION ◯ MEDICAL INFORMATION ◯ **ALL** ◯ **EXCLUDING:** _____
Employer and/or School: ◯ Employer ◯ School	◯ APPOINTMENT/ABSENTEE INFORMATION
Spouse, Parent, Other: ◯ SPOUSE (PLEASE PROVIDE NAME ON LINE BELOW) NAME: _____ ◯ PARENT (PLEASE PROVIDE NAME ON LINE BELOW) NAME: _____ ◯ OTHER (PLEASE PROVIDE NAME ON LINE BELOW) NAME: _____ RELATIONSHIP TO PATIENT: _____	◯ BILLING INFORMATION ◯ FINANCIAL INFORMATION ◯ MEDICAL INFORMATION ◯ **ALL** ◯ **EXCLUDING:** _____ Special Requests Here: _____
◯ GENERAL OR SOCIAL MEDIA VIEWING	◯ PHOTOS (WE WILL NEVER POST PHOTOS WITHOUT YOUR PRIOR APPROVAL) ◯ REVIEWS/COMMENTS/LIKES/SHARES ◯ OTHER _____

Purpose: The purpose of this authorization is to meet the patient's request for information disclosures and uses.
Expiration date or event: This authorization shall be enforced until revoked by the patient.
Rights of the Patient: I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient/Personal Representative-as defined by HIPAA Date

For Office Use Only:

Receiving Employee: _____ Date Received: _____
☐ Copy given to patient

Acknowledgement of Receipt of Notice of Privacy Practices for Southern Shores Dental

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____ _____

Signature: Patient's Name / Personal Representative (as defined by HIPAA) Date

Description of personal representative: _____
(Please attach copy of documentation to this form)

For Office Use Only:

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____

_____ _____

Employee preparing document (print name) Date

_____

Employee Signature

Southern Shores Dental

110 Charter Oak Road • Lexington, SC 29072 • (803) 359-6143

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.

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relates to your past or future physical or mental health or condition and related health care services.

We are required by law to follow the practice described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes.

You may obtain a copy of our Notice of Privacy practices at any time by calling our office or requesting one at your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION

TREATMENT: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example, we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

PAYMENT: We may use and disclose your information to obtain payment for services we provided to you. For example, we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided. This office does family billing and you will be asked to sign authorization approval.

HEALTHCARE OPERATIONS: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contact with the third party to protect the privacy of your protected health information.

OTHERS INVOLVED IN YOUR HEALTH CARE: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care to help with your health care or with payment for your health care, but only if you agree. it we determine it is in your best interest based on our professional judgement or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

EMERGENCIES: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION: Other uses and disclosures of four protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

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 law requires the use or disclosures. The use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et. seq.

PUBLIC HEALTH: We may disclose your protected health information for public health 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. Additionally, 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.

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 hearth 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.

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.

MILITARY ACTIVITY AND NATIONAL SECURITY: When the appropriate conditions apply, we may disclose to military authorities, protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

WORKERS' 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 you protected health information if you are an inmate of a correctional facility and your physician created or received your protected health in formation in the course of providing care to you.

YOUR RIGHTS

Your rights with respect to your protected health information and how you may exercise those rights are outlined below.

You have a right to obtain a copy and/or inspect your health information: Health information includes treatment records, billing records and any other records uysed by us to make decisions about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of this Notice to obtain information about our fees or is you have any questions about your access.

You have the right to request a restriction on the use and disclosure of your protected health Information: You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some pan of your information to family and others who may be involved in your care and for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but it we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.

You have a right to request to receive confidential communications by alternative means or 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 request an amendment to your protected health Information: You may request that we amend protected health information about you. Your request must be in writing with an explanation as to why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You 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 made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003, for up to the previous 6 years. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12-month period, we will charge you a reasonable cost-based fee for responding to the additional request.

You have the right to obtain a paper copy of this notice from us, upon "quest, even If you have agreed to accept this notice electronically.

QUESTIONS AND COMPLAINTS

If you have any questions, concerns or want more information about our privacy practices, please contact us using the information below.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made regarding your access to your health information or any other requests you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.

We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

CONTACT OUR OFFICE:

Southern Shores Dental

110 Charter oak Road • Lexington, SC 29072 • Office: (803) 359-6143 • Fax: (803) 359-6140

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.