Patient Info

Patient Personal Information

First Name
Last Name
Middle Initial
Preferred Name
Date of Birth
Marital Status
Gender
Social Security #
Driver's License

Patient Contact Information

Home Phone #
Cell Phone #
Work Phone #
Email Address
Address
Address 2
City
State
Zip

Patient Communication Preferences

Email
Text message

Responsible Party Personal Information

Who is the responsible party?
First Name
Last Name
Middle Initial
Preferred Name
Date of Birth
Social Security #
Driver's License

Responsible Party Contact Information

Home Phone #
Cell Phone #
Work Phone #
Email Address
Address
Address 2
City
State
Zip

Responsible Party Communication Preferences

Email
Text message

Insurance Notice

Please don't forget to bring your insurance card if this is your first appointment with us OR if your insurance information has changed.

Signature

Date of signing
Relationship to the patient
Name

Financial Policy

Patient Name: **Birth Date:**

Thank you for choosing our office as your oral health provider. It is a responsibility that we take very seriously. We are aware that our patients often have questions regarding insurance payments. Your dental benefit program will help you to obtain and maintain a superlative level of oral health.

It is important to realize that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. It is important to be aware of your insurance coverage. Our office will help you anyway we can, however our patients assume the final responsibility. Please know that we cannot recommend treatment based on insurance coverage. Our patient's dental health is our first priority.

Below are a few of our financial policies.

- Insurance companies pay a percentage of the fee of your services, therefore your estimated co- payment (the portion not covered by your insurance company) is due on the date of service. Once you consent to treatment you bear full responsibility for your account balance. This includes services your insurance company may deny.
- While we try our best to accurately anticipate what your insurance will pay, that amount may vary from the original estimate. If a balance remains after we receive the insurance payment and your co-payment, we will invoice you for the balance. After three months, any outstanding payments due from insurance will be directed to the patient.
- Please send any payment due promptly upon receipt of your statement. If your balance is not paid in a timely manner, and has to be sent to an outside collection agency, you will be responsible for the fee imposed in addition to the balance on account.
- If you prefer not to receive future statements, you can pay your visit fee in full at the time of service and have your insurance company reimburse your directly. If our office is unable to collect from an account in a timely fashion, we will then ask for payment in full and direct reimbursement from the insurance company to the patient.
- Those with extensive treatment plans may want to consult with our financial manager to set up a personal payment schedule.
- Please provide us with your dental insurance information so that we may process your insurance in a timely manner. If this information is not available for your first visit, we will collect full payment and when you inform us of your information we will submit your services to the insurance and have them reimburse you.

The fee for any appointment cancelled or broken without at least 24 hours notice is as follows:

- **Doctor's appointment = $150**
- **Hygiene appointment = $75**

Failure to provide notice inhibits us from extending the appointment to another patient. For your convenience, we will accept MasterCard, Visa, Amex, Debit Cards, Care Credit, Cash and Checks. If for some reason you need alternate arrangements, please speak to our financial manager. If you have any questions regarding the financial policy of this office, please feel free to speak with us.

Signature

Date of signing

Relationship to the patient

Name

Insurance Info

Patient Information

First Name
Last Name
Middle Initial

Primary Insurance

Do you have dental insurance or will you be paying for yourself?
Company Name
Type of plan
Subscriber Id
Group Number
Medicaid Id

Insured

First Name
Last Name
Date of Birth
Social Security Number
Driver's License
Address
Address 2
City
State
Zip

Employer

Is the plan through an employer?
Company Name
Address
Address 2
City
State
Zip

Secondary Insurance

Do you have secondary dental insurance?
Company Name
Type of plan
Subscriber Id
Group Number
Medicaid Id

Insured

First Name
Last Name
Date of Birth
Social Security Number
Driver's License
Address
Address 2
City
State
Zip

Employer

Is the plan through an employer?
Company Name
Address
Address 2
City
State
Zip

Signature

Date of signing
Relationship to the patient
Name

Notice of Privacy Practices

Patient Name: **Birth Date:**

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2014, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment

We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment

We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations

We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief

We may use or disclose your health information to assist in disaster relief efforts. Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities

We may disclose your health information for public health activities, including disclosures to:

o Prevent or control disease, injury or disability;
o Report child abuse or neglect;
o Report reactions to medications or problems with products or devices;
o Notify a person of a recall, repair, or replacement of products or devices;
o Notify a person who may have been exposed to a disease or condition; or
o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS

We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation

We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement

We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities

We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and 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 your PHI 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 instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research

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

Coroners, Medical Examiners, and Funeral Directors

We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising

We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting

With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction

You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication

You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach

You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice

You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Paul E Pederzani DMD

Telephone: 603-880-3496, Fax: 603-886-9493

Address: 20 Merrit Parkway Nashua NH 03062

E-mail: info@maplewooddentist.net

Signature

Date of signing

Relationship to the patient

Name

HIPAA Acknowledgment

Patient Name: **Birth Date:**

Date of Birth

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

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 us by phone or email.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I understand and acknowledge my rights as detailed in the Notice of Privacy Practices Presented here.

Signature

Date of signing

Relationship to the patient

Name

Authorization Form for Use or Disclosure of Patient Information

Patient Name:_____

Patient's Date of Birth:_____ Patient's Chart No.: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Description and purpose of the patient information to be used or disclosed

[ ] Medical Records

[ ] Treatment Records

[ ] Diagnostic Records

[ ] Treatment Costs/Financial Arrangements

I authorize the following person(s) to make this use or disclosure:

Maplewood Dental Group

The following person(s) may receive this patient information:

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at:
20 Merrit Parkway Nashua NH 03062. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs:

_____

Signature of Patient or Patient's Personal Representative:

_____Date_____

If Personal Representative:

Print Name:_____

Signature:_____Relationship to Patient:_____

For office use only: Copy of signed authorization provided to the individual:
Date:_____
Initials:_____

Release Form

Send to Previous Dental Office

Former Providers Information

Office Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the release of my xrays and written chart or copies of such and request that they be transferred to:

Maplewood Dental Group
20 Merrit Parkway
Nashua NH 03062
Attn: Lisa

If you have digital xrays they can be emailed to: info@maplewooddentist.net

Patient Information:

Patient Name: _____ Date of Birth _____

Patient Name: _____ Date of Birth _____

Patient Name: _____ Date of Birth _____

Patient Name: _____ Date of Birth _____

Patient or Parent Signature: _____

Todays Date: _____