NORTHCUTT DENTAL

Thank you for choosing **Northcutt Dental** as your health care provider.
To better serve you, we ask all patients to complete our patient information form completely before seeing the dentist or hygienist. PLEASE PRINT CLEARLY.

PATIENT INFORMATION (AGES 17 AND UNDER)

Name: _____ _____ _____ _____
Last Name First Name Middle Name Preferred Name

Address: _____ Apt#: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SSN: _____ – _____ – _____ DOB: _____ / _____ / _____ ☐ Male ☐ Female

How did you hear about us? _____

Who in your family has been here before? _____

In case of emergency, whom should be contact? (Someone not living with child)

Name: _____ Relationship to child: _____

Phone: _____ Address: _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account? _____ Relationship to Patient: _____

Mother/Legal Guardian's Name: _____ Work Ph: _____ Cell Ph: _____

Father/Legal Guardian's Name: _____ Work Ph: _____ Cell Ph: _____

Email address for confirming appointments: _____

Does the patient have insurance? ☐ Yes ☐ No **(If No, skip to next page)**

Primary Insurance Company: _____ Subscriber's Relationship to Patient: _____

Subscriber's Name: _____
Last Name First Name Middle Name

Date of Birth: _____ / _____ / _____ SSN: _____ – _____ – _____

Subscriber's Employer: _____ Employer Phone: _____

Additional Insurance? ☐ Yes ☐ No

Secondary Insurance Company: _____ Subscriber's Relationship to Patient: _____

Subscriber's Name: _____
Last Name First Name Middle Name

Date of Birth: _____ / _____ / _____ SSN: _____ – _____ – _____

Subscriber's Employer: _____ Employer Phone: _____

I hereby authorize payment directly to Northcutt Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Northcutt Dental to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Patient Signature (Responsible Party) Date

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Is your child currently under medical treatment? ☐ YES ☐ NO If yes, for what? _____

MEDICATIONS:

List any medications you are currently taking and why:

Medication:	**Reason for Use:**

Check any known allergies:

None	☐	Local Anesthetics	☐
Aspirin	☐	Penicillin	☐
Codeine	☐	Other:_____	☐
Latex	☐		

Check "YES" or "NO" for each of the following:	YES	NO
Anemia/Free Bleeder	☐	☐
Asthma	☐	☐
Blood disease	☐	☐
Cancer (type: _____)	☐	☐
Diabetes: Type I or Type II	☐	☐
Epilepsy or seizures	☐	☐
Head Injuries	☐	☐
Heart Problem	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Mental Disorders	☐	☐
Respiratory Disease	☐	☐
Tuberculosis	☐	☐

Does your child have any other health issues we should be aware of? ☐ YES ☐ NO

If yes, for what? _____

_____

ASSIGNMENT and RELEASE

I give permission for Northcutt Dental and their clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my child's dental needs.

I understand that under the Health Insurance Portability and Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I understand that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

_____ _____

Parent Signature (Responsible Party) Date

FOR OFFICE USE ONLY

DATA ENTERED BY: _____ INITIALS

COPY OF DL AND/OR INS CARD OBTAINED: _____ INITIALS

SCANNED TO DOCUMENT CENTER BY: _____ INITIALS

FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please read carefully.

ALL COPAYMENTS, DEDUCTIBLES, AND/OR ESTIMATED PATIENT PORTIONS ARE DUE ON THE DATE TREATMENT IS PERFORMED.
We accept cash or Visa/MasterCard/American Express/Discover. We offer an extended payment plan with credit approval.
We do not accept checks.

REGARDING INSURANCE: We are happy to accept assignment of insurance benefits from your insurance carrier. As a courtesy to you, we will file your insurance, help you maximize your benefits, and estimate both your insurance coverage and your portion due. Your estimated portion is due upfront (before treatment) on date of service. Should your insurance company refuse to comply with assignment of benefits, you will be asked to pay your bill in full and be reimbursed by your insurance company. **The balance is the patient's responsibility whether the insurance company pays or not.** If the insurance company has not paid the account in full within 45 days, the balance becomes the patient's responsibility. Should Northcutt Dental have to expend any fees (collection, court cost, etc.) to collect any payment portion, insurance or other, these fees will automatically become the patient's responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under some dental insurance policies.

MISSED APPOINTMENTS: There is a $50.00 Late Cancellation/No Show Fee for patients who do not call us at least 24 hours in advance to cancel or reschedule appointments that do not require a deposit.

DEPOSITS: A deposit is required for most appointments and will be applied toward your treatment cost. However, it is **non-refundable** and will be **forfeited** if the appointment is canceled, rescheduled, or if you change the scheduled procedure(s) without at least **24 hours' notice**.
Deposit Requirements:

- Appointments over $1,000: 10% of the total appointment cost
- Appointments under $1,000: $50-$100

If a deposit has been made, the standard $50 missed appointment fee does not apply; instead, the forfeited deposit serves as the penalty.

RETURN CHECK FEE FOR MAILED PAYMENTS: Any returned check will incur a $50.00 NSF fee.

PAYMENT OF SERVICES: Your estimated portion is due upfront (before treatment) on date of service.

CREDIT CARD PAYMENTS: We have a 3% Cash/Debit discount built into all pricing. A fee of 3% will be assessed to each credit card transaction, which is not greater than our cost of acceptance.

MINOR PATIENTS: The adult accompanying a minor is responsible for seeing that payment is made in full. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made for payment by cash, credit card or pre-approved credit.

AGREEMENT TO PAY COLLECTION FEES ADDED TO ACCOUNT BALANCES: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

CONSENT TO CONTACT PATIENT BY CELL PHONE OR E-MAIL: You agree, in order for us to service your account or to collect monies you may owe, Northcutt Dental and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which can result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

LATE CANCELLATIONS & NO-SHOWS: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice. A "no-show" is someone who misses an appointment without cancelling it in an adequate manner.

- First late cancellation or no-show: A one-time courtesy reschedule is offered for appointments that do not require a deposit. For appointments with a required deposit, the deposit will be forfeited if proper notice is not given.
- Second late cancellation or no-show: For appointments with a deposit, the deposit will be forfeited. For appointments without a deposit, a $50.00 fee will be charged and must be paid before scheduling any future appointments.
- Third late cancellation or no-show: Discharge from the practice

By signing below, you agree that you have read, understand and agree to our Financial Policy above. Please let us know if you have any questions or concerns regarding this policy. We look forward to serving your dental needs.

Patient Signature (Responsible Party) _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI 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 health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 01/01/2018, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

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

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third-party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Kathryn Hornung
Address: 23678 US Highway 98, Fairhope, AL 36532
Telephone: 251-279-6171
Fax: 251-928-8724
Email: admin@northcuttdental.com