ENDODONTIC associates

PLEASE PRINT

PATIENT'S NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

DRIVER'S LICENSE # _____ EMAIL _____ SOCIAL SECURITY # _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____

SPOUSE/GUARDIAN/PARENT NAME _____

SPOUSE/GUARDIAN/PARENT ADDRESS _____

REFERRED BY _____ GENERAL DENTIST _____

DENTAL INSURANCE _____ CONTRACT/ID # _____

GROUP # _____ SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____ SUBSCRIBER'S SOCIAL SECURITY # _____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING: (Please check if YES)

- ❍ HEART DISEASE/HEART ATTACK
- ❍ HEART MURMUR
- ❍ HEART SURGERY PACEMAKER
- ❍ MITRAL VALVE PROLAPSE
- ❍ RHE UMATIC FEVER
- ❍ RHEUMATIC HEART DISEASE
- ❍ STROKE
- ❍ PROSTHETIC ARTIFICIAL)
- ❍ HEART VALVE
- ❍ ANGINA
- ❍ CONGENITAL HEART DEFECT
- ❍ OTHER HEART CONDITIONS
- ❍ HIGH BLOOD PRESSURE
- ❍ TUBERCULOSIS
- ❍ EMPHYSEMA
- ❍ ASTHMA
- ❍ SINUS PROBLEMS / ALLERGIES
- ❍ HEPATITIS Type: A B or C
- ❍ JOINT REPLACEMENT (HIP, KNEE, ETC.) SURGERY IN THE PAST YEAR
  DATE _____
  REASON _____
- ❍ STOMACH ULCERS DIABETES
- ❍ MRSA
- ❍ STAPH
- ❍ THYROID DISORDERS
- ❍ STEROID THERAPY
- ❍ EPILEPSY FAINTING
- ❍ SPELLS/SEIZURES
- ❍ BLOOD TRANSFUSION
- ❍ BLEEDING PROBLEMS
- ❍ ANTICOAGULANTS (BLOOD THINNERS)
- ❍ ANEMIA (LOW BLOOD) LEUKEMIA
- ❍ HEARING IMPAIRED
- ❍ LIVER DISEASE
- ❍ TMJ (JAW JOINT) PROBLEMS
- ❍ CANCER/TUMOR
- ❍ VENEREAL DISEASE
- ❍ HIV POSITIVE AIDS-ACQUIRED IMMUNE DEFICIENCY SYNDROME
- ❍ DRUG DEPENDENCY
- ❍ PARKINSON'S DISEASE
- ❍ DO YOU PREMEDICATE WITH ANTIBIOTICS FOR DENTAL PROCEDURES? IF YES, NAME OF ANTIBIOTIC _____
- ❍ OTHER MEDICAL CONCERNS _____

DO YOU WANT NITROUS OXIDE (LAUGHING GAS)?

❍ **YES** ❍ **NO** (your insurance will not cover this)

ARE YOU TAKING ANY MEDICATIONS?

❍ **YES** ❍ **NO**

PLEASE LIST MEDICATIONS YOU ARE TAKING:

_____

_____

ARE YOU ALLERGIC TO:

- ❍ ASPIRIN ❍ LATEX
- ❍ PENICILLIN ❍ SULFA
- ❍ CODEINE ❍ NOVOCAINE
- ❍ IBUPROFEN ❍ ANESTHESIA
- ❍ OTHERS (Please List) _____

ARE YOU PREGNANT? ❍ **YES** ❍ **NO**

ARE YOU UNDER THE CARE OF A PHYSICIAN? ❍ **YES** ❍ **NO** If yes, why?

PHYSICIAN'S NAME & PHONE#

PATIENT'S SIGNATURE (GUARDIAN/PARENT IF MINOR)

DATE	TOOTH	RECORD OF TREATMENT

TOOTH NO.						

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ENDODONTIC INFORMED CONSENT AND PAYMENT POLICY

- It is important that you maintain your scheduled appointments or the infection can reoccur.
- Treatment will require a series of diagnostic radiographs and may require more than one visit.
- Endodontic treatment has a high degree of success, and a tooth with previous root canal treatment tends
- to have a lower success rate. There is no guarantee of success.
- Accurate and complete disclosure of medical information is necessary for proper diagnosis, and to help
- prevent unnecessary complications during your treatment.
- The most common complications with root canal therapy includes:

  → Continued infection requiring surgery or extraction
  → Side effects and reactions to medication
  → Fracture of the tooth or crown during or after treatment. Porcelain crowns are subject to breakage
  → We recommend that all posterior teeth be crowned following root canal treatment. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support
  → Tenderness and pain following treatment is normal for 24-48 hours

- Other treatment options are, no treatment, waiting for more localized symptoms or extraction. Risks with
- these options may include pain, infection, swelling, loss of the tooth or infection in other areas.
- **AT COMPLETION OF YOUR ROOT CANAL, YOU NEED TO MAKE AN APPOINTMENT WITH YOUR GENERAL DENTIST FOR A PERMANENT RESTORATION.**

OUR OFFICE DOES NOT ACCEPT MONTHLY PAYMENT PLANS

NITROUS OXIDE SEDATION IS OPTIONAL AND CHARGED SEPARATELY. NITROUS OXIDE IS NOT COVERED BY INSURANCE AND PAYMENT IS THE PATIENT'S RESPONSIBILITY, THE CHARGE IS $50.00, IF YOU CHOOSE THE NITROUS OXIDE.

This is a referral practice, and a mutual respect to obligations is essential to permit our business to be conducted on an efficient and friendly basis. Therefore, to avoid misunderstandings concerning payments of accounts, please note that endodontic treatment is usually completed in one visit, and must be paid in full. **You must provide our office staff with the proper information Dental Insurance Card, Social Security No., and Date of Birth of the person you are filing dental insurance under must be paid in full the day of the office visit.**

Any discrepancy between the Insurance Company's allowance and your total indebtedness remains your responsibility. **Any insurance claim that has not been paid within 60 days of treatment will be billed back to you.**

I hereby assign, transfer, and set over to Endodontic Associates, P.C. all rights, title, and interests to my dental reimbursement benefits under my insurance policy, I authorize the release of any dental information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges for my dependents, or myself whether or not they are covered by insurance. I,the under-signed, agree to pay and understand that a finance charge of 18% per month will be added to all account balances that become over 60 days past due. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency, (33.33%), attorney fees and/or court costs, if such be necessary.

Telephone Consumer Protection Act (TCPA):

You agree, in order for us to service your account or to collect monies you may owe, Endodontic Associates, P.C., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could 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.

I / We have read this disclosure and agree that Endodontic Associates, P.C., its employees and/or agents may contact me/us as described above.

Responsible Party Signature: _____ **Date:** _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, acknowledge that I have received a Notice of Privacy
(PLEASE PRINT NAME) Practices from the above-named practice.

_____

Patient or Personal Representative's Signature Date

IF A PERSONAL REPRESENTATIVE SIGNS THIS AUTHORIZATION ON BEHALF OF THE INDIVIDUAL, COMPLETE THE FOLLOWING:

Personal Representative's Name: _____

Relationship to Individual:_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❍ Individual refused to sign
- ❍ Communications barriers prohibited obtaining the acknowledgment
- ❍ An emergency situation prevented us from obtaining acknowledgment
- ❍ Other (Please Specify) _____

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information 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 or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: 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, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reason- able inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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

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 a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.99 for each page, $11.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

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

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alter- native means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Telephone: (205) 661-6050
Address: 4700 Misty Ridge Circle, Birmingham, Alabama 35235

PATIENT FINANCIAL AGREEMENT & RELEASE OF INFORMATION

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. PAYMENT. Payment of any unmet deductible, co-insurance, co-payment, and any charges not covered by insurance is expected at the time of your visit. We accept cash, check and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service.

2. INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE

- It is your responsibility to confirm which treatments or procedures are covered and/or paid by insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
- As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. In order to bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
- We can only approximate the percentage covered by each plan. Payment of the ESTIMATED portion as well as your co-payment is due at time of service.
- Any estimate of insurance coverage may differ from what your insurance carrier ultimately pays. You will be responsible for any charge that insurance determines to be not covered.
- **NOTE: If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service
- As the parent or guardian accompanying a minor, you are financially responsible for all charges, whether or not paid by insurance.
- In situations of divorce, separation, court orders, etc., the adult who signs in a minor child on the day of treatment accepts financial responsibility for payment.
- Non-covered procedures will not be filed to insurance.
- Medicare does not cover in-office general anesthesia or dental related procedures including extractions.
- Adults 21 years of age and older are not eligible for dental coverage through Medicaid.
- Private pay/uninsured patients must pay in full at time of service.

3. BILLING AND COLLECTION

- Returned checks will be subject to a fee of up to $30.00, except where prohibited by law.
- Payment is due as stated on any billing statement mailed, emailed or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past-due.
- Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
- Past due accounts may be placed with a collection agency or attorney for collection.
- In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees (either 33.33% of the amount due or the maximum amount allowed by applicable law), reasonable attorney's fees and expenses, collection expenses, and court costs. If your account is turned over to collections, you hereby accept any such fees and costs as a legal and lawful debt and agree to paid said fees, including any and all resulting fees and costs. You hereby waive your right of exemption under any applicable laws.
- If your account is turned over for collections, you will no longer be able to receive services from the Practice until your delinquency is cured.

4. CONSENT TO CONTACT. The Practice and anyone contacting you on our behalf may contact you for any purpose and in any manner permitted by law. You also expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We and/or anyone contacting you on our behalf may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the Practice, and anyone contacting you on our behalf, may communicate with you in any manner, including through the use of an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

I have read the financial policies above, and my signature below indicates my agreement to these policies and acceptance of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any services provided to me, I assume financial responsibility and will pay all such charges in full.

I hereby authorize the Practice to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Practice all insurance benefits otherwise payable to me for the Practice's services.

_____	____/____/____
Patient Name	Patient DOB
_____	_____
Patient or Responsible Party Signature	Date
_____	_____
Printed Name of Responsible Party (if applicable)	Relationship to Patient (if applicable)