DANVILLE
FAMILY DENTISTRY
Lisa Neal, DMD | Jessica Popplewell, DMD

Hello and thank you for allowing us to assist you.

We are delighted that you selected our office to provide you with optimum oral health. Because your dental health is our #1 priority, we strive to provide you with the highest quality of dental care in a safe and comfortable healthcare environment.

We pride ourselves on our *"we care"* communication style by carefully listening to your concerns and answering all of your questions prior to making any recommendations. To keep you informed, we make it a point to fully disclose the process of each procedure and all associated fees prior to appointment scheduling. The bottom line is we want our patients to take an active role in the decision making process which will enable them to achieve and maintain optimum oral health for a lifetime.

During your first visit with us we will address your initial concerns and desires and gather your current medical and dental history. Please complete the forms included with this letter and bring them with you to your appointment. If you need any assistance completing them, we will gladly assist you at your first appointment. To ensure that we collect your information correctly, we ask that you bring a list of any prescriptions or over-the-counter drugs or supplements that you are currently taking. If you have dental insurance, be sure to bring that information along with you as well so that we may assist you in maximizing your benefits and submitting your claims.

It is the timeliness of our patient's arrivals which allow us to run an "on-time" practice. Unless we have an urgent interruption to our schedule, you can expect us to be on time. If for some reason you find yourself delayed in your arrival or experience a change in your schedule, please contact our office immediately to allow us to offer your reserved time to another patient in need.

You will find directions on our website. If you have any questions or concerns, please feel free to give us a call. We look forward to providing you with the best in dental care.

Warmest regards,

Drs. Neal, and Popplewell

132 North 2nd Street, Danville, KY 40422 --- 859-236-2488

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PATIENT REGISTRATION

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Name _____
First MI Last Preferred Nickname

Sex ☐ M ☐ F Date of Birth _____/_____/_____ ☐ Single ☐ Married ☐ Child ☐ Other

Home Address _____
Street City State Zip

Phone #'s (_____) _____ (_____) _____ (_____) _____
Home # Work # Mobile #

Social Security # _____ E-mail Address _____

Employer _____
Name Address City State Zip

How did you hear about our office? _____

Contact in case of emergency _____ (_____) _____
Name Relationship Phone #

☐ Spouse *or* ☐ Parent, if minor _____ (_____) _____
Name Address Phone #

Person Responsible for Account _____
Name Relationship SS#

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____

Subscriber's ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card *or* please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union #, if any _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____

Subscriber's ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card *or* please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union #, if any _____

AUTHORIZATION

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____

I understand this office may photograph my face and mouth for purpose of documentation in my patient chart. _____ (Initial if consenting)
I further grant my permission for this office to use my photographs for purposes of educating other patients, including placing them on our website.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____

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MEDICAL HISTORY

Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Are you under a physician's care now? ☐ Yes ☐ No If so, for what? _____

_____

Physician's Name _____ Phone # (_____) _____

Are you taking (or supposed to be taking) any medications, vitamins or herbal supplements? ☐ Yes ☐ No Please list below

_____

_____

_____

_____

Are you pregnant? ☐ Yes ☐ No If yes, due date _____

Do you use e-cigarettes or any form of tobacco? ☐ Yes ☐ No _____

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or alendronate? ☐ Yes ☐ No

Are you allergic to any medications or substances? ☐ Yes ☐ No If yes, please check boxes below.

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine

☐ Latex or Rubber ☐ Other _____

Have you ever had a reaction or experienced complications to any dental treatment in the past? ☐ Yes ☐ No

Please check "yes" if you presently have or have had in the past any of the following conditions:

Yes		Yes		Yes	
☐	Heart Trouble/Disease	☐	Lung or Breathing Problems	☐	Severe Headaches
☐	Heart Murmur	☐	Shortness of Breath	☐	Fainting or Dizzy Spells
☐	Irregular Heart Beat	☐	Sinus Trouble	☐	Epilepsy, Seizures or Convulsions
☐	Angina or Chest Pain	☐	Asthma	☐	Sleep Apnea
☐	Heart Attack or Failure	☐	Chronic Cough	☐	Hepatitis, Jaundice or Liver disease
☐	Congenital Heart Disorder	☐	Emphysema	☐	Arthritis, Gout or Rheumatism
☐	Mitral Valve Prolapse*	☐	Tuberculosis (TB)	☐	Artificial Joint*/Replacement
☐	Rheumatic Fever	☐	Frequent Sore Throat	☐	Cholesterol Problems
☐	Artificial Heart Valve*	☐	Tumor or Cancer	☐	Stomach or Intestinal Disease
☐	Heart Pacemaker*	☐	X-ray or Cobalt Treatment	☐	Thyroid Disease
☐	Heart Surgery	☐	Chemotherapy	☐	Kidney or Bladder Problems
☐	Stroke	☐	Enlarged Lymph Nodes (Glands)	☐	Renal Dialysis
☐	Aneurysm	☐	Swelling of Limbs	☐	Hypoglycemia
☐	High Blood Pressure	☐	Bruise Easily	☐	Excessive Thirst
☐	Low Blood Pressure	☐	HIV Positive or AIDS	☐	Diabetes
☐	Bleeding Disorder	☐	Transplant Recipient	☐	Psychiatric Care
☐	Blood Transfusion	☐	Major surgery	☐	Chemical Dependence/Substance Abuse
☐	Anemia	☐	Scarlet Fever	☐	Other: _____

*Conditions denoted above with asterisk may require antibiotics prior to treatment. We may need to contact the physician treating you for these conditions. _____

Pharmacy name and phone number: _____

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____

APPOINTMENT AND FINANCIAL POLICIES

DANVILLE FAMILY DENTISTRY
Lisa Neal, DMD | Jessica Popplewell, DMD

Welcome to our office!
We believe in optimum communication with our patients; therefore, we ask that you please read the following information and ask any and all questions so we may help you fully understand our financial and appointment policies.

FOR OUR PATIENTS FORTUNATE ENOUGH TO HAVE DENTAL BENEFITS:
Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Some insurance companies will downgrade procedures to a lesser expensive treatment, leaving you to pay the remainder; we have no control over what the insurance companies choose to do regarding payment. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is for reference only and should not be your only basis for proceeding with treatment. We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can (including electronic claims submission). We are more than happy to file any secondary insurance claims for you; however, because of the inconsistencies in secondary insurance benefits, we do not attempt to estimate what the secondary insurance plan will cover. We collect estimated portions calculated by our computer system up front; if there is any remaining balance after receiving all insurance, it will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 90 days after the claim, the remaining balance will be due and payable by you. Thanks for your understanding.

FINANCIAL AGREEMENT (FOR ALL PATIENTS):
Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility for payment of fees. Treatment is to be paid in full when services are rendered unless other arrangements have been discussed and finalized. This may be in the form of Cash, Check, Visa, MasterCard or other outside financing. Any balances over 90 days old will be sent to a professional credit reporting/collection agency. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including attorney's fees.

REGARDING APPOINTMENTS:
Our time is valuable and so is yours. Our commitment to you is:

- We will not ask you to make a schedule change unless it is an extreme emergency.
- We will always be conscious of your personal time and will try to start your dental appointments on time and complete your treatment as efficiently as possible.

Please understand that **we reserve chair time just for you** when you make an appointment with us. In an effort to continually provide quality service, we ask that you keep your reserved appointment as it is scheduled. Kindly give **48 hours (or more)** notice if you need to change your appointment. In the case of a failed appointment, you may be placed on our standby list. Our standby list patients are called if and when we get a short notice opening in our schedule.

Appointment Confirmation: We will contact you approximately 2 days prior to your scheduled appointment to confirm the date and time. If we are not able to reach you, we ask that you return our call to speak with one of our staff members and verbally confirm your appointment. If we don't get a verbal confirmation at least one day prior to your appointment, we will assume that you will not be here and may need to give that date and time to another patient in need.

Please keep us informed of any changes to your health information as well as your address, phone, email or insurance information so that we may serve you in the best possible manner.

I have read and understand the above financial policies. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

X _____ _____ _____

(Patient or Parent or Guardian signature) (Date) (Print patient's name)

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REGARDING PATIENT PRIVACY

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I authorize the office to share my protected health information with the following persons:

Name	Relationship to Patient

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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132 North 2nd Street
Danville, KY 40422
(859) 236-2488

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION – PLEASE READ IT CAREFULLY.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on April 14, 2003.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient for health care from one provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation of customer service given to our patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice.

We may contact you (by telephone, through voicemail messages, text messages, email or with postcards or letters) to provide appointment reminders, or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information;
- You have the right to amend protected health information; however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you have the right to file a formal written complaint.