Notice of Privacy

As a provider of medical services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of insurance coverage.

OUR DUTY TO YOU

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information, about you and your treatment under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during the course of treatment. This includes releasing information to other dentist, physicians, other health care providers and our staff. Our staff includes full and part time employees, as well as, temporary personnel.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies, and third party administrators such as employee medical reimbursement accounts.

Operations: We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for the other purposes than as described above. Examples of these uses include: appointment reminders (cards, voice messages and letter), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operations or payment), and in some cases to law enforcement and court ordered releases.

YOUR RIGHTS

Restrictions: You have the right to restrict to request restrictions or disclosure usage. We are not required to accept these restrictions but we will make a note to the request and honor that request if applicable.

Access: Your have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule and appointment to view your information. You may also request a copy of your personal health information We will charge you a fee for the copies as set by the Texas State Board of Dental Examiners.

Amendment: You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such request We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to ament your information.

Disclosures: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12 month period.

Complaints: Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you submit a written complaint U.S. Department of Health and Human Services. We can provide you with the address upon request.

HORIZON DENTAL INSURANCE ACCEPTANCE CONTRACT

Dental insurance is a highly complex area that creates confusion for many dental patients. The complexities of dental insurance and lack of sufficient information provided by some insurance companies, delay timely payment to dental providers. It has become such a burden on staff and resources to provide the courtesy of filing patient insurance, that some dental offices will no longer accept dental insurance at all.

Horizon Dental does not want to go to this extreme, though we have made a change in policy. **Our office will complete and submit claims to your insurance company to achieve the maximum reimbursement to which you are entitled and will work diligently to make this happen as quickly as possible.**

However, any insurance claim not paid within 60 days of being submitted, will have the balance billed directly to your credit card that we will require to be on file. Any Insurance information requested from the insurance company that we need from you to process your claim that is not received within 30 days, will have the balance billed directly to your credit card.

Please remember, dental insurance is a contract between your employer and a dental insurance company. In the event the dental insurance company refuses to pay for treatment, or delays payment beyond 60 days of being submitted, you are responsible for all fees.

Our office remains dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves on helping you in any way and in continuing to provide the quality of care to which you have become accustomed.

I understand and agree to the above.

_____ _____

Patient/Cardholder Signature Date

CREDIT AUTHORIZATION FORM

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

Zip Code: _____

I authorize Horizon Dental to charge the above referenced credit card for unpaid balance at or beyond 60 days. I also understand that Horizon Dental will store the above listed information in a secured location.

PATIENT MEDICAL HISTORY

HORIZON dental

Physician_____ **Office Phone** _____

Office Address_____

Approximate date of last physical examination _____

	Yes	No
1. Are you allergic to Penicillin?	☐	☐
2. Have you ever had any adverse response to any drugs?	☐	☐
What were they?		
3. Have you had any major operations?	☐	☐
If so what?	☐	☐
4. Have you ever had a serious accident involving head injuries?	☐	☐
5. Has a physician ever informed you that you had: a Heart Ailment?	☐	☐
6. High Blood Pressure?	☐	☐
7. Respiratory disease?	☐	☐
8. Diabetes?	☐	☐
9. Rheumatic Fever?	☐	☐
10. Rheumatism or Arthritis?	☐	☐
11. Tumors or Growths?	☐	☐
12. Any blood Disease	☐	☐
13. Any Liver Disease	☐	☐
14. Any Kidney Disease	☐	☐
15. Any Stomach or Intestinal Disease	☐	☐
16. Any Venereal Disease	☐	☐
Which ..... HIV?	☐	☐
17. Yellow Jaundice or Hepatitis	☐	☐
18. Can you carry on your usual normal activities?	☐	☐
19. Can you climb a flight of stairs without resting?	☐	☐
20. Do your ankles swell as the day progresses?	☐	☐
21. Have you ever awakened at night short of breath?	☐	☐
22. Have you had a recent large weight gain?	☐	☐
23. Do you have night sweats accompanied by weight loss or cough?	☐	☐
24. Are you on a diet at this time?	☐	☐
25. Are you now taking drugs or medications?	☐	☐
What are they?	☐	☐
26. Are you allergic to any known materials resulting in hives, asthma, eczema, etc?	☐	☐
27. Have any wounds healed slowly or presented other complications?	☐	☐
28. Are you pregnant?	☐	☐
29. Do you have a history of fainting?	☐	☐
30. Have you ever had any X-RAY TREATMENTS (other than diagnostic)?	☐	☐
30. Have you taken any osteoporosis medication within the past 5 years?	☐	☐

32. Who referred you to this office. _____

In case of emergency notify _____

Telephone Number _____

Patient Name _____ Date of Birth _____ Age _____ ☐ M

Address _____ Home Phone _____ ☐ F

City _____ State _____ Zip Code _____ Patient S.S. # _____

Responsible Party _____ Insured Employer _____

Insured's Name _____ Name of Ins. Co. _____

Insured's S.S. # _____ Single ___ Divorced ___ Email: _____

Married _____ Widowed _____ Cell Phone _____

Place of birth _____

PATIENT MEDICAL HISTORY

	Yes	No
1. Are you pleased with the appearance of your teeth?	☐	☐
2. Do you have pain in or near your ears?	☐	☐
3. Are you aware of any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
4. Have you experienced any growth or sore spots in your mouth?	☐	☐
5. Does any part of your mouth hurt when clenched?	☐	☐
6. Have you ever had Novocaine anesthetic?	☐	☐
7. Any reactions or allergic symptoms to novocaine	☐	☐
8. Have you ever had Nitrous Oxide?	☐	☐
9. Do you with to have dentistry in combination with Nitrous Oxide?	☐	☐
10. Any difficult extractions in the past?	☐	☐
11. Prolonged bleeding following extractions in the past?	☐	☐
12. Trench Mouth?	☐	☐
13. Do Your gums bleed?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instruction on the care of your gums?	☐	☐
16. Do you chew on only one side of your mouth?	☐	☐
If so why?	☐	☐
17. Do you habitually clench your teeth during the night or day?	☐	☐
18. Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)	☐	☐
If so locate	☐	☐
19. When was your last full mouth X-RAY taken?	☐	☐
20. What is your main complaint about your mouth or teeth?	☐	☐

21. How will you pay for treatment not covered by insurance?

☐ CASH OR CHECK ☐ VISA, MASTERCARD, DENCHARGE

The answers to the above questions are true to the best of my knowledge:

PATIENT SIGNATURE _____ DATE _____

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

I will be responsible for all fees not paid by insurance company.

_____

RESPONSIBLE PARTY SIGNATURE