

AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION FORM

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

Authorization to Speak with Family/Friend (including spouses)

I give the following named person(s) authorization to take messages or speak with the office of Anthem Dentistry on my behalf regarding (please check all items authorized):

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

I understand my express consent is required to release my health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed below.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Notice of Privacy Practices

Federal & State laws require Anthem Dentistry to maintain the privacy of all patient healthcare information. Furthermore, we are required by law to provide all parents or legal guardians with this notice reviewing our privacy practices, our legal obligations, and your rights in regard to your child's healthcare information. Anthem Dentistry must follow the privacy practices as described within this notice while this policy is in effect. This notice takes effect on February 1st, 2008 and will remain in effect until replaced, amended, or eliminated.

Anthem Dentistry reserves the right to change these privacy practices and the terms of this notice at any time provided such applicable laws permit such changes. We reserve the right to make any needed changes to our privacy practices and these new terms will be effective for all health information that we maintain, including health information we create or receive before such made changes. Before we make any significant changes to our privacy practices, we will change this notice and make new notice available upon request.

Parent or legal guardians may request a copy of this notice, at any time. For additional information about our privacy practices or to review our company's Health Insurance Portability & Accountability Act (HIPAA) Manual, please contact our office at any time.

USES & DISCLOSURES OF HEALTHCARE INFORMATION

Anthem Dentistry will use and disclose patient healthcare information during your treatment, while obtaining payment from insurance companies and during general healthcare operations. For example:

Treatment. Anthem Dentistry may use your health information during direct treatment or by disclosing such information to other dentists, physicians or healthcare providers who may provide specialized treatment for you.

Payment. We may also use and disclose your health information to obtain payment for services rendered. We may disclose your healthcare information to another healthcare provider or entity that is also subject to these same federal & state privacy rules and regulations for payment activities.

Healthcare Operations. We may use and disclose your healthcare information during our routine healthcare operations. Healthcare operations may include quality assessments and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities. We may disclose your healthcare information to another healthcare provider or organization that is subject to the same federal & state privacy rules and regulations and that has a relationship with you during the support of healthcare operations. We may disclose your information to help such organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals, or detect or prevent healthcare fraud or abuse.

On Your Authorization. You may give Anthem Dentistry written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any issues or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason except those described within this notice.

To Your Family & Friends. 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 previously performed healthcare services. Before we disclose your health to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event you are incapacitated and cannot make a decision for yourself, or in the event of an emergency, we will disclose your medical information based on our professional judgment of practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical/dental supplies, radiographs or other similar forms including health information. We may also use or disclose information about you to notify or assist in notifying a person involved in his/her care.

Appointment Reminders. Anthem Dentistry may use or disclose your healthcare information to provide you and your family with appointment reminders. (Such as: telephone calls, voice messages, postcards, or letters)

Disaster Relief. We may use or disclose your healthcare information, as authorized by federal or state law for the following purposes deemed to be in the public's best interest or benefit:

- As required by law

- For public health activities, including disease and vital statistic reporting, reporting child abuse or neglect, FDA oversight and to employer's regarding work-related illness or injury.
- To health oversight agencies
- In response to court and administrative orders and lawful processes
- To law enforcement officials pursuant to subpoena and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and for purposes of identifying or locating a suspect or other persons.
- To coroners, medical examiners and funeral directors
- To an organ procurement organization
- To avert serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- To correctional institutions regarding inmates
- As authorized by state worker's compensation laws

PATIENT or PARENT/LEGAL GUARDIAN RIGHTS

Access. You have the right to look at or receive a copy of your health information, with limited expectations. You may request that we provide a copy in format other than photocopies. We will use the format you request unless we cannot practically do so. You must make all requests in writing to obtain access to your child's healthcare information. You may request access by sending us a letter. If you request a copy, we will charge you a reasonable fee, which may include labor, copying costs and postage. 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 may, but are not required to, prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting. You have the right to receive a list of instances in which Anthem Dentistry or any business associates disclosed your health information over the past year (but not prior to June 24th 2010). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you and certain activities. 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 the use or disclosure of your healthcare information. We are not required to agree with such additional restrictions, but if we do, we will abide by our agreement (except in the event of an emergency). Any agreement we make to a request for additional restrictions must be in writing and signed by our privacy officer. Your request is not binding unless our agreement is in writing.

Alternative Communication. You have the right to request that we communicate with you about your health information by an alternative means or at an alternative location. You must make your request in writing. You must specify in your request the alternative means or location and satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment. You have the right to request that we amend your healthcare information. Your request must be in writing and should explain why you are requesting this amendment. We may deny your request under certain circumstances.

QUESTIONS OR COMPLAINTS

If you need additional information regarding our office's Privacy Practices & Regulations or have specific questions or concerns, please feel free to contact us. Furthermore, if you believe that:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly
- Our response to a previous request to amend or restrict the use or disclosure of your information was incorrect
- We should communicate with you by alternative means or an alternative location

You may submit a written complaint with our privacy officer or directly to the US Department of Health & Human Services. We will provide you with these addresses to file your complaint, upon request. We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health & Human Services.

I understand the contents of the previous notice concerning the privacy of my confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Anthem Dentistry from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

Signature of Patient/ Parent or Guardian

Date

Dental Practice Policies and Financial Agreement



Anthem Dentistry
Anthem Dentistry
3668 W Anthem Way #162
Phoenix, AZ 85086
(623) 551-7500
dentistry.anthem@gmail.com

Patient Name: _____

Date of Birth: _____

Responsible Party/Guardian: _____

Relationship to the patient: _____

Signature: _____

Date: _____

Welcome

Welcome to Anthem Dentistry. We appreciate the opportunity to provide you with quality dental care. To ensure clear communication and efficient service, please review the following policies carefully. Your signature below confirms your understanding and agreement.

Appointments & Missed Appointments

We reserve time specifically for you. If you are unable to keep your scheduled appointment, please provide at least **48 business hours' notice**.

Failure to provide proper notice or failure to appear for a scheduled appointment may result in a broken appointment fee as follows:

- **Missed appointment with the Dentist: \$100.00**
- **Missed appointment with the Hygienist: \$50.00**

Repeated missed appointments may result in dismissal from the practice.

We make every effort to run on time. If you arrive more than **15 minutes** late, we may need to reschedule your appointment.

Occasionally emergencies arise that cause delays. We respect your time and will make every effort to stay as close to your appointment time as possible.

Payment Policy

Payment is due at the time services are rendered unless prior arrangements have been made.

We accept cash, debit cards, and major credit cards.

If you have dental insurance:

- We will submit claims as a courtesy.

- Insurance is a contract between you and your insurance carrier.
- Estimated patient portions are due at the time of service.
- Any balance not paid by insurance within **60 days**, for any reason, becomes the responsibility of the patient.

Once insurance payment is received, any remaining balance will be billed to you. Payment of outstanding balances is due in accordance with Anthem Dentistry's financial policy. If insurance claims remain unpaid, it is the patient's responsibility to follow up with the insurance carrier. The office will continue to assist with claim processing as a courtesy. Returned checks may be subject to a fee in accordance with office policy and applicable law. Accounts not paid as agreed may be subject to interest or finance charges as permitted by applicable law and office policy.

Past Due Accounts

Accounts that remain unpaid beyond **90 days** may be referred to a collection agency. If your account is referred to collections, you agree to be responsible for collection fees permitted by applicable law, as well as reasonable attorney fees and court costs if applicable.

Treatment Estimates

Any fee estimate provided is not a guarantee of insurance payment. Actual coverage is determined solely by your insurance carrier. You are responsible for all services rendered, regardless of insurance benefits.

No Guarantee of Results

Dentistry is not an exact science and results cannot be guaranteed. No guarantee or assurance has been made regarding the outcome of treatment you have requested or authorized. Each dentist is an individual practitioner and is solely responsible for the dental care rendered.

Records Requests

Original records remain the property of the practice. Upon written request, copies of records will be provided within the timeframe required by state law. A reasonable duplication fee may apply where permitted.

Arbitration Agreement

Patient Initials: _____

The patient and dentist (including their corporations, representatives, staff, agents, parents, guardians, children, and all related individuals and entities) agree that all disputes arising from events that occurred in the dental office will be determined through submission to an arbitrator, and not by a lawsuit or other legal proceeding filed in a federal, state, county, or municipal court.

By signing this Arbitration Agreement, the parties waive and forfeit their constitutional, statutory, or common law rights for a judge or jury to decide disputes, and instead accept the use of a private arbitrator. This Arbitration Agreement covers all disputes related to dental treatment, financial matters, or any other events that occurred in the dental office—whether in tort (intentional or negligent), contract, statute, common law, or otherwise—including, without limitation, actions relating to dental negligence, return of fees, loss of consortium, wrongful death, discrimination, emotional distress, or punitive damages. The arbitration shall bind all parties, including any spouse or heirs, and will not be subject to court review. Either party may initiate arbitration by serving on the other a written "Demand for Arbitration" by certified mail (no other form of service will be acceptable). The Demand for Arbitration must identify all parties, include contact information, describe the claims against each party, and state the amount of damages sought. Either party may continue the proceedings by contacting the American Arbitration Association (AAA). A single AAA arbitrator, mutually selected by the parties, will conduct the arbitration. Proceedings will be resolved using AAA rules. **The laws of the state in which services are rendered will apply.** If any provision of this agreement is held invalid or unenforceable, the remaining provisions remain in full force and effect.

Acknowledgment & Signature

I have read, understand, and agree to the policies outlined above. I acknowledge that I have had the opportunity to ask questions.

Patient Information

Please Print

Title: _____ First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Patient Social Security #: _____ Patient Date of Birth: _____ Sex: **M** **F**

Email Address: _____ May we contact you by email? **Yes** **No**

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

**If patient is under the age of 18, Parent or Guardian please fill out below:*

Parent / Guardian Name: _____

Date of Birth: _____ Social Security #: _____

Insurance Information

Do you have Dental Insurance? **Yes** **No**

Primary Insurance					Secondary Insurance				
Subscriber Name: _____					Subscriber Name: _____				
Subscriber SSN: _____					Subscriber SSN: _____				
Date of Birth: _____					Date of Birth: _____				
Relationship to Subscriber:					Relationship to Subscriber:				
Self	Spouse	Child	Other		Self	Spouse	Child	Other	
Employer Name: _____					Employer Name: _____				
Employer Phone: _____					Employer Phone: _____				
Insurance Company: _____					Insurance Company: _____				
Insurance Group # _____					Insurance Group # _____				
Insurance Phone # _____					Insurance Phone # _____				
Insurance Address: _____					Insurance Address: _____				

Please present insurance card and Drivers License

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes No DK				Yes No DK				
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes	No	DK				Yes	No	DK
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.											
			Yes	No	DK				Yes	No	DK
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No	DK	Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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