CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal at Eastman Family Dental Center is to provide quality dental care in a timely manner. We do understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 24-hour (business hours) notice whenever possible if they cannot keep an appointment. This allows us time to refill our schedule with other patients who may be waiting. We appreciate your understanding and consideration regarding our cancellation and failed appointment policy.

Like many offices, we provide text and verbal confirmations several days prior to your scheduled appointment. It is your responsibility to notify our office if you need to make any changes to your appointment.

We **REQUIRE A CONFIRMED APPOINTMENT**. If you fail to provide us with confirmation, we have the right to cancel your appointment. _____________ (initial)

- Cancellation or rescheduling of an appointment within 24 hours or more will result in no charge.
- A failed appointment is an appointment that is cancelled/rescheduled without 24 hours' notice or an appointment where a patient does not show up.
- We do allow for one broken appointment as a courtesy.
- After two (2) failed appointments, we may require a deposit of 100% that will be applied to your appointment, to reserve any future appointments. **This is non-refundable.**
- After three (3) failed appointments, you will be dismissed from the practice.

By signing, you are acknowledging you have read and understand our cancellation/missed appointment policy.

Print Patient Name: ____ Date Of Birth:_____________

____ Date ____________________

Signature of Responsible Party

(if minor, signature of Parent or legal guardian is required)

Eastman Family Dental Center

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 REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice.

This Notice describes the privacy practices of Eastman Family Dental Center ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Eastman Family Dental Center's Privacy Official at:

Tiffany Bailey

421 Plaza Avenue

Eastman, GA 31023

478-374-4716

866-479-9734

info@eastmanfamilydentalcenter.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal, and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information 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 protected health information.
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on August 5, 2020.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect, or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If the use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in the format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable, and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is August 5, 2020.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Acknowledgement of Receipt of Notice of Privacy Practice

I, ____, have received a copy of this office's notice of Privacy Practices.

______________________________________ ______________________________

Signature Date

For office use only

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

- The individual refused to sign.
- Communication barrier prohibited obtaining the acknowledgement.
- An emergency prevented us from obtaining acknowledgement.
- Other (please specify) ____

Eastman Family Dental Center

421 Plaza Ave.

Eastman, GA 31023

(478) 374-4716

Patient's Name: ____

Patient's Parent, Guardian or Spouse: ____

Patient's Date of Birth: ____________________ Patient's SSN: _________________

Patient's Mailing Address: ____

____

Patient's Street Address: ____

____

Male________ Female_________ Patient's Marital Status: ___________

Patient's Employer: ____

Home Phone: _____________________ Business Phone: ___________________

Cell Phone: _______________________ Email: _____________________________

How do you prefer to be contacted to confirm your appointment? Phone____ Email____

Pt. Pharmacy name and location: ____

Pt. Medical doctor: Name, Address, and Phone Number: ______________________________

____

Please list any members of your immediate family who are patients:

____

Please list the name, relationship, and phone numbers of a person **not living in your household** whom we would contact in case of an emergency:

____

Medical History

Patient Name___________________________ Date__________________

YES NO 1. Are you under the care of a physician?
If so, what is the condition being treated? _____________________________

YES NO 2. Have you had any serious illness or operation?
If so, what and in what year? ____

3. Do you have, or have you had any of the following conditions or problems?
Please circle ALL that apply.

YES NO A. Rheumatic fever or Rheumatic heart disease?
YES NO B. Congenital heart lesions, heart murmurs, or Mitral Valve Prolapse?
YES NO C. Cardiovascular disease **please circle** (heart trouble, heart attack, coronary insufficiency Coronary occlusion, high blood pressure, arteriosclerosis, stroke stent)
YES NO D. Do you have any type of valve or pacemaker for your heart?
YES NO E. HIV or AIDS (Acquired Immune Deficiency Syndrome)
YES NO F. HPV
YES NO G. Hepatitis
YES NO H. Diabetes
YES NO I. Seasonal Allergies
YES NO J. Sinus Trouble
YES NO K. Fainting spells
YES NO L. Seizures
YES NO M. Tuberculosis
YES NO N. Do you have a joint prosthesis (**artificial hip, knee, etc**.)?
Date of Placement__________
Name and number of surgeons__________________________

YES NO 4. Do you smoke? _________ Chew tobacco? ___________ Dip Snuff? ______________
YES NO 5. Have you had surgery or x-ray treatment for a tumor, growth, or other condition?
YES NO 6. Have you had abnormal bleeding associated with a tumor, growth, or other condition?
YES NO 7. Please list any Drug, Medication or pill you are currently taking:

____

____

YES NO 8. Do you have any allergies to any medications?
If so, please list: ____________________________________

YES NO 9. Women- Are you pregnant? If so, when is your due date? _________________

YES NO 10. Do you take or have you taken bisphosphonates? **Please circle**: Actonel Fosamax Boniva Reclast, Didronel, Zometa Binosto Aclasta, Aredia, Atelvia, Skelid

Dental History

What is the usual frequency that you have your teeth cleaned? ______________ Last visit? _________________

YES NO 1. Do your gums bleed easily?
YES NO 2. Have you had any unusual difficulties with any previous dental treatment?
YES NO 3. Are you satisfied with the appearance of your teeth?
YES NO 4. Is there any condition that you feel your dentist should know about prior to treatment?
If so, describe: ________________________________

To the best of my knowledge, the above medical and dental history is correct. I hereby consent to such examinations, x-rays, and diagnostic procedures, as well as any treatment you may prescribe.

____ ____

(Signature of Patient, Parent or Legal Guardian) (Signature of Dentist)

Dental Insurance

Name of Dental Insurance Company ____

Please provide a copy of your insurance card at the front desk

Your insurance is a contract between you and your insurance company. If, for any reason, your insurance fails to pay, YOU are responsible for FULL payment.

I authorize the release of any information necessary to process my dental insurance claims. I understand that I am responsible for all costs of dental treatment.

Sign ____ Date ___________

(Patient or Parent of Minor)

I hereby authorize payment directly to Eastman Family Dental Center of the insurance benefits otherwise payable to me.

Sign ____ Date ____________

(Insured Person)

Uninsured

I understand that payment is due on the date services are rendered and accept full responsibility of payment for services provided.

Sign ____ Date ____________

**** If the insurance is drawn on your spouse or patent/guardian, please list the following information:**

Subscriber name: ____

Date of Birth: ___________________________________

SSN: ____

Authorization to release protected health information.

I authorize the use or disclosure of the protected health information ("PHI") as described below; I authorize the custodian of the PHI:

(1) To discuss the PHI with the person(s) identified below, and
(2) To furnish the person(s) identified below with a copy of the PHI if he or she so requests.

Patient Name: ___________________________________ DOB: _________________

Description of PHI requested: entire contents of dental record, including diagnosis, treatment details and financial information.

I Authorize **Eastman Family Dental Center** to release and/or disclose the PHI described above to the following person(s)

Person 1: ____

Person 2: ____

I understand that I have the right to revoke this authorization, in writing, at any time by so notifying the requesting person. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this authorization. However, if I refuse to sign this authorization, I understand that I will be financially responsible for all dental work performed by this office.

____ _______________________

Signature of Patient Date