

WELCOME TO OUR PRACTICE

This form is designed to acquaint you with our Office Policies. You have the opportunity to question, at this time and prior to service, the Office Policies and Procedures in the following areas of concern.

Please INITIAL each of the items below

This office employs licensed, board certified Dentist and Hygienist, who will be involved in your patient care and providing your dental treatment.

Policy on cancellation and rescheduling requires 48 business hours notice in advance. (When you receive your reminder call, you must call us back and let us know you received the call). Thank you.

Failure to give 48 business hours advance notice of cancellation may result in a minimum of \$50.00 for the Office Visit.

Patients are responsible to know their insurance benefits prior to their first visit.

NSF checks has a (\$30.00) recovery fee and (Thereafter cash only).

Statements are billed twice a month. Expectant payment is within 10 days of the statement date.

Insurance Billing- We bill your insurance the same day of service, electronically.

Notification of change of insurance, job, name, address and phone number is the patient's responsibility.

All established patient phone calls are triaged through the dental assistants and/or office staff.

Diagnostic and Treatment Codes for Billing will NOT be altered for insurance billing purposes.

Pharmacies: Patients must supply the office with their pharmacy name and phone number.

Co-pay and Service Fees are due at the time of service and prior to treatment for patient comfort.

If pre-treatment instructions have not been followed, your procedure may be canceled.

18 years and under must be accompanied by a parent or guardian.

My initials above and my signature below signify that I have read the above items and understand the counseling I have received.

Printed
Name _____ **Signature** _____ **Date** _____

Smile Evaluation Checklist

Name: _____ Date: _____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

- | | | |
|---|-----|----|
| Do you dislike the color of your teeth? | YES | NO |
| Do you have spaces between your teeth that bother you? | YES | NO |
| Do you have chips or uneven edges on your teeth? | YES | NO |
| Do you feel that your teeth are too long or too short? | YES | NO |
| Do you have dark fillings that show when you smile? | YES | NO |
| Do your gums show too much when you smile? | YES | NO |
| Are your teeth crowded or crooked? | YES | NO |
| Do you have existing crowns or dental work that you consider “ugly”? | YES | NO |
| Are you self-conscious of your teeth and/or smile? | YES | NO |
| Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile? | YES | NO |
| Do you avoid smiling when you have your picture taken? | YES | NO |
| Would you like to improve your existing smile? | YES | NO |
| Do you wish you had a “new smile”? | YES | NO |

What concerns do you have regarding dental treatment to improve your smile?

- Fear of treatment
- Time of treatment concerns
- Financial concerns
- Distance to office
- Not understanding treatment
- Embarrassment
- Other

FINANCIAL OPTIONS & GUIDELINES

This form is designed to notify you of our office policies regarding methods of payments we offer you, including acceptance of insurance.

METHOD OF PAYMENT

- ___ CASH, CHECK, CREDIT CARD/ DISCOVERY CARD
___ VISA, MASTERCARD, AMERICAN EXP, DEBIT CARD
___ THIRD PARTY FINANCING (CC) & (C-1) PLEASE ASK!

OPERATIONAL POLICIES

Major Procedures require a deposit to hold the space and time that is completely dedicated for your treatment, therefore we must secure that space and time with a deposit that assures us you will be keeping that appointment.

INSURANCE RELATIONSHIP

We are very happy you have an insurance to assist you in the payment for these procedures, however, please know that our relationship is with you, our patient, not the insurance company. We bill and trace your insurance for payment, however you are ultimately responsible for payments.

PAYMENT AT THE TIME OF SERVICE

Payments are made at the time of services. Our patients appreciate taking care of their business with the front desk, prior to treatment and while waiting. This cuts down on the time they have to spend waiting at the end of service. Also while their comfort level is higher.

Print Name _____ Signature _____ Date _____

Authorization to Release Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

Doctor's Name: Andrew W. Kelly DDS
Practice Name: Dental Center of the Carolinas

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip code: _____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

Or _____ All health care information

Or _____ Other: _____

THIS AUTHORIZATION **EXPIRES** ON _____, or _____ DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS: if I am no longer an active patient of this practice.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Signature of patient or patient's authorized representative Date signed

Relationship or status if signed by parent, legal guardian, personal representative, etc.

Dental Center of the Carolinas
Dr. Andrew W. Kelly, DDS

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 practices and the terms of this Notice at anytime, 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 anytime. 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 this 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 reasonable inferences of your best inferences 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 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 authorize federal officials health information required for lawful intelligence counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of 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 practicably 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 send* us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.10 for each page, \$6.00 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 alternative 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 a complaint with us or with the U.S. Department of Health and Human Services

Attention: Angie Russell, Office
Manager Telephone: 336-766-7966
Address: 100 Stadium Oaks Drive, Suite A
Clemmons, NC 27012



DENTAL CENTER
of the Carolinas | *Implants*
Dentures
General
Andrew W. Kelly, DDS | *Cosmetic*

AGREEMENT AS TO RESOLUTION OF CONCERNS

“I, Patient/Guardian” shall be understood to mean _____, (insert name of patient or guardian)

“Doctor” shall be understood to mean Andrew W Kelly D.D.S. of Dental Center of the Carolinas.

Further, I understand that I am entering into a contractual relationship with the Doctor for professional care. Further I understand that meritless and frivolous claims for medical/dental malpractice have adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Doctor, I the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Doctor.

Furthermore, should a meritorious medical/dental malpractice case or cause of action be initiated or pursued, I (the patient or my representative) agree to use dental witness(es) who are board-certified in the same specialty as the Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and or code of conduct defined for expert witnesses by the American Dental Association.

In further consideration for this, Dr Andrew W. Kelly agrees to the same stipulations.

Doctor

Patient or Guardian

Effective from Date of Treatment

Date of Signature