Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Leslie A. Mitchell, DMD
440 Villa Rd.
Newberg, OR 97132
(503) 538-9389

Policy on Broken Appointments

Our office has a 24 hour cancellation policy. There is a $50.00 charge per scheduled appointment not kept. After 3 broken appointments or same day cancellations, you will be put on a "Same day ONLY" status.

Signing this statement does not constitute agreement or disagreement with the policy described. Signing merely indicates you have been informed of our office policy regarding broken dental appointments.

I HAVE READ AND UNDERSTAND THE ABOVE:

_____ Date:_____

Signature of patient or parent

Dental Concerns Assessment

Patient's Name_____ Date_____

Please rank your concerns or anxiety over the dental procedures listed below.

Please fill in any additional concerns.

	Level of Concern				
	None	Low	Med.	High	Explain
1. Anesthetic ("Novocaine") ……					
2. Radiographs ("X-Rays")…….					
3. Jaw getting tired…….....					
4. Gag reflex……					
5. Fear of being injured……					
6. Not being in control or able to stop the dentist……..					
7. The amount of treatment needed……..					
8. Sounds and/or smells in the dental office…….					
9. Not feeling free to ask questions or to be listened to……					
10. Receiving too little information…….					
11. Too many short appointments or too long of appointments…					
12. Please rate your smile					
(Dislike it) 1 2 3 4 5 6 7 8 9 10 (Love it)					
Do you require premedication or Nitrous Oxide with your dental care?					
Comments:					

Let us keep the Sparkle in your Smile

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Phone _____ Alt. Phone _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐M ☐F Age _____ Birthdate _____

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____Years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ SS/HIC/Patient ID # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependants covered under this plan _____

Additional Insurance

Is patient covered by additional insurance _____

Subscriber name _____ Relation to patient _____ Birthdate _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependants covered under this plan _____

Please complete both sides

Dental History

Reason for Today's Visit _____ Date of Last Dental Care _____

Former Dentist _____ Date of last Dental x-rays _____

Address _____

Check (✓) if you have had any problems with any of the following:

- □ Bad breath
- □ Bleeding gums
- □ Clicking or popping jaw
- □ Food collection between Teeth
- □ Grinding teeth
- □ Loose teeth or broken fillings
- □ Periodontal treatment
- □ Sensitivity to cold
- □ Sensitivity to hot
- □ Sensitivity to sweets
- □ Sensitivity when biting
- □ Sores/growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Feslin (brand names of phentermine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints
- □ Asthma
- □ Back Problems
- □ Blood Disease
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Cortisone Treatments
- □ Cough, Persistent
- □ Cough up Blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart Murmur
- □ Heart problems
- □ Hemophilia
- □ Hepatitis
- □ High Blood Pressure
- □ HIV/AIDS
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Shortness of Breath
- □ Skin Rash
- □ Stroke
- □ Swelling of Feet/Ankles
- □ Thyroid Problems
- □ Tobacco Habit
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease

Medications: List medications you are currently taking:

_____

_____

Allergies

_____

_____

Authorization

I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian, or Persona Representative Date

_____ _____

Print name of Patient, Parent, Guardian, or Persona Representative Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ 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 your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Let us keep the Sparkle in your Smile

WELCOME TO OUR OFFICE!

ABOUT US

Dr. Mitchell is long term Oregonian resident currently making her home in Tigard. She attended Tigard High School, the University of Portland and graduated OHSU Dental School in 2002.
After 2 years of clinical practice in Portland, Dr. began private practice in Newberg on November 1, 2004.
Dr. is a member of the ADA, ODA and AGD as well as our local dental society and is a firm believer in continuing education, keeping abreast of current innovations and improving patient care.
She enjoys family time, gardening, reading, camping, watching sports and practicing dentistry.
Our carefully selected team members are exceptionally skilled, highly educated individuals excelling in expanded function dental assisting, dental hygiene and dental business administration.
Our entire team is dedicated to the belief that patient education and prevention is one of the best tools we can provide to our patients in helping them achieve excellent dental health.

OUR MISSION

We will offer high-quality, friendly service in a gentle, caring atmosphere. Our patients are the heart of our practice and the reason we are here. At all times our patients will be treated with respect, dignity and compassion. Being of service to our patients is the definition of our purpose and the mission of our practice.

PATIENT SERVICES

The services we provide include:
Comprehensive Exams~Oral Cancer screenings~Professional consultations~Diagnostic Imaging~
Cleaning~Periodontal Treatment~Laser Therapy~Fluoride~Oral-B toothbrushes~Instruction
~Patient Education~
Nightguards~Dentures~Partials~Crowns~Bridges~Composite Fillings~In-Office Whitening
Root Canal Therapy~Sealants~Extractions~Implant Placement & Restorations~Advanced Esthetic Dentistry

HOURS OF APPOINTMENT

Our office hours are:
Monday and Tuesday 8:30am – 5pm / Wed 8:30am - 6:00pm/ Thurs 8:30am – 3pm
Fridays by appointment
Hours are by appointment and we strongly believe in the value of your time.
We strive to honor scheduled appointment times and appreciate your cooperation in this regard.
When emergencies occur, we will do our utmost to see you in a timely manner.

FOR YOUR COMFORT

You may wish to bring your own favorite music selections or use the I-Pod provided by the office.
We use tinted glasses for ease of viewing and provide Nitrous Oxide sedation, if desired.

PAYMENT OPTIONS

We are proud to provide several options to our patients for payment of dental services.
You may choose from:

1. Full payment at appointment with 5% discount (5% additional for seniors)
2. Insurance billing with payment of estimated portion at appointment
3. Extended payment plan (ask our Office Manager for details)

For your convenience, we accept cash, checks, Visa, MC and money orders

ABOUT INSURANCE

As an insurance consumer, you are probably aware of the constant changes in benefits, co-pays, deductibles and coverage by your insurance company. We currently work with many insurance plans and do our best to keep up with these changes. We gladly submit dental charges to your insurance on your behalf and will do our best to provide you with the most accurate estimate of coverage available to us at the time of service. We ask that all our patients be aware that they are ultimately responsible for any and all charges incurred as a result of treatment. **Please be prepared at your first appointment by bringing your benefit booklet.**

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