HIPAA 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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required BY Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.
DENTAL HEALTH HISTORY
Confidential

Today's Date ____________________

Patient Name_____________________________ Birthdate, ________

Last Name _____________________________ First Name _______, Initial ________

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 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 or 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 had any serious illnesses or operations? ________ If yes, describe __________________________

Have you ever had a blood transfusion? [ ] Yes [ ] No If yes, give approximate dates __________________________

Have you ever taken any of the group collectively referred to as “fen-phen?” These include combinations of ionomin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux ( dexfenfluramine.) [ ] Yes [ ] No

(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
- [ ] Cough, Persistent
- [ ] Cough up Blood
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [ ] Glaucoma
- [ ] Headaches
- [ ] Heart Murmur
- [ ] Heart Problems
- [ ] Heart Murmurs
- [ ] Hepatitis
- [ ] 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 or Ankles
- [ ] Thyroid Problems
- [ ] Tobacco Habit
- [ ] Tonsillitis
- [ ] Ulcer
- [ ] Venereal Disease
- [ ] Artificial Heart Valves
- [ ] Cough, Persistent
- [ ] Cough up Blood
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [ ] Glaucoma
- [ ] Headaches
- [ ] Heart Murmurs
- [ ] Hepatitis
- [ ] HIV/AIDS
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- [ ] Mitral Valve Prolapse
- [ ] Pacemaker
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- [ ] Respiratory Disease
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- [ ] Scarlet Fever
- [ ] Shortness of Breath
- [ ] Skin Rash
- [ ] Stroke
- [ ] Swelling of Feet or Ankles
- [ ] Thyroid Problems
- [ ] Tobacco Habit
- [ ] Tonsillitis
- [ ] Ulcer
- [ ] Venereal Disease

MEDICATIONS

List medications you are currently taking:

- [ ] Aspirin
- [ ] Barbiturates (Sleeping pills)
- [ ] Codeine
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] HIV/AIDS
- [ ] Local Anesthetic
- [ ] Penicillin
- [ ] Sulfur
- [ ] Latex
- [ ] Other

ALLERGIES

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_________________________________________ Date

Signature of Patient, Parent, Guardian or Personal Representative

_________________________________________

Please print name of Patient, Guardian or Personal Representative

_________________________________________ Relationship to Patient

#13/01 — Medical Arts Press® 1-800-328-9219
Dream Dental
Office Policy

Welcome to Dream Dental. Please read and sign the following stating that you understand our office policy.

Payment is expected at the time of service.

I elect to pay: Cash ____ Check _____, Master/Visa/American Express/Discover ____ Care Credit ____.

For those desiring monthly payments, we have made arrangements with Care Credit to do just that. For your convenience, you may pay as little as 3% of your total bill, or you can pay your bill in full with no interest penalties. There is no annual fee for Care Credit. If you desire to arrange for Care Credit billing we will provide you with an application form and process it for you.

If you have dental insurance:
You will be required to pay any out of pocket expense at each visit. Dental insurance was not designed to pay for ALL dental care. All levels of payment by insurance companies, including allowed fees, usual and customary fees, are governed by the premiums that you pay. They have nothing to do with the actual charges. When we verify your coverage over the telephone with your insurance company, it is only an ESTIMATE of your actual out of pocket expense. We will not know exactly what the insurance will pay until we receive payment for the claim. Most questions regarding coverage should be addressed to your employer or your insurance company.

If treatment is for your child or a minor:
In the case of single parent custody, separation of parents or legal guardianship by another family member or friend, the person who signs this payment policy will be held ultimately responsible for payment of this account. If Parent(s) do have legal guardianship, but child is taken care of by a family member or friend, we will require consent for treatment from the legal guardian before treatment more than an exam, x-rays, and/or cleaning be performed.

If you cannot keep a scheduled appointment, we ask as a courtesy that we be given 24 hour notice of cancellation otherwise a $50 cancellation fee will be added to your account.

In an effort to control the increasing cost of dental care, any claims or disputes against this office shall be resolved by "binding arbitration." By signing this agreement, the patient agrees with the office of David A. Weaver DMD P.C., that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement [including associates] shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as this section.

I have read the above, I understand the payment policy and agree that I am responsible for any charges incurred regardless of insurance coverage. I also agree to be held responsible for any attorney or collection fees incurred for collection of an overdue account.

Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above.

Signature:
# DREAM DENTAL

900 Conference Drive  
Suite 6A  
Goodlettsville, TN 37072  
Telephone: (615) 859-7117

Date ______________  
Home Phone (___)  
Cell Phone (___)

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>SS/HIC/Patient ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
<td></td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Sex</td>
<td>M</td>
<td>F</td>
<td>Age</td>
<td>Birthdate</td>
</tr>
<tr>
<td>Patient Employer/School</td>
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<tr>
<td>Employer/School Address</td>
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<tr>
<td>Whom may we thank for referring you?</td>
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<tr>
<td>In case of emergency who should be notified?</td>
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</tbody>
</table>

## PRIMARY INSURANCE

<table>
<thead>
<tr>
<th>Person Responsible for Account</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Relation to Patient</th>
<th>Birthdate</th>
<th>Soc. Sec. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (If different from patient's)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>City</td>
<td></td>
<td></td>
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<td>State</td>
<td>Zip</td>
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<tr>
<td>Person Responsible Employed by</td>
<td></td>
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<td></td>
<td>Occupation</td>
<td></td>
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<tr>
<td>Business Address</td>
<td></td>
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<td>Business Phone (___)</td>
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<tr>
<td>Insurance Company</td>
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<td></td>
</tr>
<tr>
<td>Contract #</td>
<td>Group #</td>
<td>Subscriber #</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Names of other dependents covered under this plan</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## ADDITIONAL INSURANCE

| Is patient covered by additional insurance? | Yes | No |
| Subscriber Name | | | Birthdate |
| Address (If different from patient's) | | | |
| City | | | State | Zip |
| Subscriber Employed by | | | Business Phone (___) | |
| Insurance Company | | | Soc. Sec. # | |
| Contract # | Group # | Subscriber # |
| Names of other dependents covered under this plan | | | | |

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with Name of Insurance Company(ies) and assign directly to Dr. Name of Insurance Company(ies) 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 doctor 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 services 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 Personal Representative  
Date  
Relationship to Patient

Please print name of Patient, Parent, Guardian or Personal Representative
**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: __________________________ Signature __________________________ Date __________