KC DENTAL – NOTICE OF PRIVACY PRACTICES AND HIPAA

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 Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically on paper, or orally, are kept confidential. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

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.

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.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment.
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent.
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we decide in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

PATIENT RIGHTS

You have the following rights with respect to your protected health information, which can be exercised by written request:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you.
- To request that we communicate with you about your health information by alternative means or to alternative locations.
- The right to inspect and copy your protected health information. If you request copies, we will charge you $25 for each set of X-Rays.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

QUESTIONS AND COMPLAINTS

If you have any questions about our privacy practices, or if you feel that your privacy protections have be violated, you have the right to file a formal, written complaint with us or with the Department of Health & Human Services office at the addresses below:

KC Dental
Daniel Wang – Privacy Officer
6301 W. Parmer Lane, #606
Austin, TX 78729

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201

Appointment Cancellation Policy

We understand that unplanned issues arise and you may need to cancel or change an appointment. If that happens, we respectfully ask for advanced notice. Our doctors and hygienists want to be available for your needs and the needs of all of our patients. When a patient doesn't show for an appointment another patient loses an opportunity to be seen.

As of July 1st, 2014, there will be a fee assessed based on length of appointments if we do not receive a call for cancelation or change with the appropriate number of business hours needed.

Thank you for being a valued patient and for your understanding and cooperation as we instate this policy. This policy will allow us to open otherwise unused appointments to better serve the needs of all patients.

Sincerely,
The Staff at KC Dental

Length of Appointment	**Hours prior needed to cancel**	**Cancellation Fee (non-compliance)**
1 hour or less	24 business hours	$25.00
1-2 hours	48 business hours	$50.00
2-3 hours	72 business hours	$75.00
3 hour or more	1 week prior to appointment	* 50% of patient portion required to reserve the appointment * Non-refundable if patient no-shows or cancels without proper notice

Patient Information

Date : ________________________

Name (Last): ____________________________________

Name (First, MI): _________________________________

Sex: _________ Email: ___________________________

Birth Date: _______________ SS# __________________

DL#____

Home Phone: ____________________________________

Cell Phone: ______________________________________

Address: ____

City: __________________ State:_______ Zip:_________

Insurance and other information

Primary Insured Name: __________________________

Birth Date: _______________ SS#: _______________

DL#____

Relationship to Patient: __________________________

Employer: ____________________________________

Employer Phone #:_____________________________

Insurance Company: ____________________________

Group#: ________________ ID#: ________________

*********IN CASE OF EMERGENCY, CONTACT:*

Name ____

Relationship ________________Ph#________________

Financial / Insurance Filing / Notice of Privacy Practices / Cancellation Policy

1. **Financial Responsibility:** Payment is expected at the time of service.
2. I acknowledge that I have read and/or received a copy of the "Notice of Privacy Practices"
3. I acknowledge that I have read and/or received a copy of "Appointment Cancellation Policy"
4. If a patient is younger than 18 years old, a PARENT OR LEGAL GUARDIAN MUST BE PRESENT DURING THE WHOLE APPOINTMENT for us to explain the procedures and to sign the required consents. The patient will not be seen if a parent or legal guardian is not present.
5. If you are more than **10 minutes** late to your appointment it will be canceled and counted as a missed appointment.

(If we are not filing insurance on your behalf, please skip item #6)

6. **I understand and certify that I have effective insurance coverage with:**

______________________________(insurance company name)_________________________(Plan Group/ID)

- **Patient Portion: WE WILL COLLECT "PATIENT PORTION" ON THE DAY OF SERVICE.** Patient portion amount is an estimate based on Non-Binding information gathered from your insurance. The patient is responsible for any amount that insurance does not cover. If the total payment received (from insurance and patient) exceeds the treatment fee, we will refund patient the difference.
- **Filing Policy:** As a courtesy, we will file your primary insurance (**our office does NOT file secondary insurance plans**) for you for services rendered at our office. We will allow 30 days for insurance payment to your account. After 30 days, we will send you a statement requesting for any balance on your account.
- **Financial Responsibility:** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FROM SERVICES RENDERED, WHETHER OR NOT PAID BY THE INSURANCE.
- **Insurance Update:** I understand that my insurance coverage may change from time to time; it is my responsibility to inform the office whenever there is an update or change.

By signing below, I acknowledge I have read, understood and agree to the above policy.

________________________________ ___________________________ ______________

Patient Signature (if minor, guardian signature) Print Name of Signer Date

How did you hear about us? Please check ones that apply:

___ Insurance provider list ___ Drive-by ___ Newsletters ___ Yellow book ___ Website ___ other________________

___ Friend/colleague/relative Whom can we thank for this referral:_________________________________

Dental History

Reason for today's visit:

____

____

Former dentist: ________________________

City/State: ________________________

Date of last dental visit: ________________

Date of last dental x-rays: _______________

How often do you floss? ________________

How often do you brush your teeth?

____

Please circle yes or no for the following:

Bleeding gums? Yes / No

Blisters on the lips or mouth? Yes / No

Chew on one side of mouth? Yes / No

Cigarette/Pipe/Cigar Smoker? Yes / No

Clicking or popping jaw? Yes / No

Dry mouth? Yes / No

Food collection between teeth? Yes / No

Grind/clench your teeth? Yes / No

Gums swollen or tender? Yes / No

Jaw pain/tiredness? Yes / No

Bite your lips/cheeks? Yes / No

Broken fillings/ Loose teeth? Yes / No

Mouth pain when brushing? Yes / No

Orthodontic treatment? Yes / No

Pain around ear? Yes / No

Periodontal treatment? Yes / No

Sensitivity to hot, cold or sweets? Yes / No

Sensitivity when biting? Yes / No

Sores/growths in your mouth? Yes / No

Health History

Physician's Name: ____ Date of last visit: ____

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

Please circle yes or no to indicate if you have had any of the following:

AIDS/HIV Yes / No

Anemia Yes / No

Arthritis/Rheumatism Yes / No

Artificial heart valves Yes / No

Artificial joints Yes / No

Asthma Yes / No

Back problems Yes / No

Bleeding abnormally with extractions or surgery Yes / No

Blood disease Yes / No

Cancer Yes / No

Chemical dependency Yes / No

Chemotherapy Yes / No

Circulatory problems Yes / No

Congenital heart lesions Yes / No

Cortisone treatments Yes / No

Cough persistent or bloody Yes / No

Diabetes Yes / No

Emphysema Yes / No

Epilepsy Yes / No

Fainting or dizziness Yes / No

Glaucoma Yes / No

Headaches Yes / No

Heart murmur Yes / No

Heart problems Yes / No

Hepatitis Yes / No if yes, type? ______

Herpes Yes / No

High blood pressure Yes / No

Jaundice Yes / No

Jaw pain Yes / No

Kidney disease Yes / No

Liver disease Yes / No

Low blood pressure Yes / No

Mitral Valve Prolapse Yes / No

Nervous problems Yes / No

Pacemaker Yes / No

Psychiatric care Yes / No

Radiation treatment Yes / No

Respiratory Disease Yes / No

Rheumatic Fever Yes / No

Scarlet Fever Yes / No

Shortness of breath Yes / No

Sinus trouble Yes / No

Skin rash Yes / No if yes, when? ______

Special diet Yes / No

Stroke Yes / No

Swollen feet or ankles Yes / No

Swollen neck glands Yes / No

Thyroid problems Yes / No

Tonsillitis Yes / No

Tuberculosis Yes / No

Tumor or growth on head or neck Yes / No

Ulcer Yes / No

Weight loss, unexplained Yes / No

Do you wear contact lenses Yes / No

Other: ______________________________

____

FOR WOMEN

Are you pregnant? Yes / No

If yes, when are you due? ________________________________

OBGYN Name & Phone Number: ____________________________

Taking birth control pills? Yes / No

Are you nursing? Yes / No

ALLERGIES

Are you allergic to any of the following?

Aspirin Yes / No

Iodine Yes / No

Penicillin Yes / No

Codeine Yes / No

Latex Yes / No

Sulfa Yes / No

Local Anesthetic Yes / No

Barbiturates (sleeping pills) Yes / No

Other: ____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Preferred Pharmacy Name & Phone Number:

____

SIGNATURE REQUIRED: **I certify that I have read this form in its entirety and acknowledge this information is correct to the best of my knowledge:**

____

Signature Date