WELCOME

We are pleased to welcome you and/or your child 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 _____

SS/HIC/Patient ID # _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext_____ Alt. (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Work Phone (_____) _____ Ext_____ Alt. Phone (_____) _____

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? _____

Do you wear contact lenses? ☐ Yes ☐ No

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	**Have you ever had or been diagnosed with:**		
Chemotherapy	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No			
Circulatory Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Artificial Heart Valves	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Artificial Joints, Screws, Pins, etc.	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No			
Epilepsy	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No	Congenital Heart Lesions	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Special Diet/Weight Loss	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Hernia Repair	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Hepatitis Type _____	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe _____

_____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Diet Medications	☐ Yes	☐ No
Dexfenfluramine	☐ Yes	☐ No
Fen-phen	☐ Yes	☐ No
Pondimin	☐ Yes	☐ No
Redux	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

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

Are you allergic to:

Aspirin	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
Metals (i.e. gold)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No

Other _____

Please PRINT all medications now taking: _____

_____

_____

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.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) 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 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.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. ____w_____ (Name of Doctor Disclosing PHI) to use and/or disclose my Protected Health Information (PHI) related to _____ (Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed). The information will be used and/or disclosed for the purpose of _____ (Describe each purpose for which you are authorizing your Protected Health Information to be used and/or disclosed). I authorize Dr. _____ (Name of Doctor Receiving PHI) to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

DOCTOR'S COMMENTS & UPDATE (to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____

Dr. Tiffany Duncan, DMD

NAME _____
ADDRESS _____
PHONE NUMBER (HOME) _____ (CELL) _____

WHO WILL PAY FOR THIS ACCOUNT _____
PURPOSE OF THIS APPOINTMENT _____
LAST DENTAL CHECK UP _____

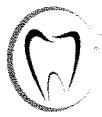
__ YES __ NO 1. Do you take aspirin daily?
__ YES __ NO 2. Are you in good health?
__ YES __ NO 3. Are you under a physician's care? If so, please give reason for treatment _____
__ YES __ NO 4. Are you taking any kind of medication? (prescription or non-prescription) _____
__ YES __ NO 5. Have you ever had an unusual reaction to novocaine or any type of other drug?
__ YES __ NO 6. Have you ever had prolonged bleeding after tooth removal?
__ YES __ NO 7. Do you take over the counter medication?

PLEASE CIRCLE ANY ILLNESS YOU HAVE HAD

A. Rheumatic Fever B. Heart Murmur C. Allergies D. Tuberculosis
E. Diabetes F. Epilepsy G. Blood Disorder H. Heart Trouble
I. Kidney Trouble J. Liver Trouble K. Hepatitis L. Other _____

_____ _____
SIGNATURE DATE

__ Please check this, after reading the statement below:
Please be advised that our office requires a minimum of 24 hours notice of confirmation of your appointments.
Failure to give confirmation at least 24 hours prior to your scheduled appointment may result in a cancellation of appointment.



Tiffany Todd Duncan, DMD
79 Mall Road, Suite B
South Williamson, KY 41503
Phone: (606) 237-0073
Fax: (606) 237-9967

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Dr. Tiffany Todd Duncan DMD and/or staff under her direction, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following:

- Dental Records
- Identification Purposes

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature (Patient) _____ Date _____

Appointment Reminders

Our office uses an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference as to how we should contact you:

☐ Home Phone ☐ Cell Phone ☐ Facebook

Written Communication

☐ OK to mail to my home address ☐ OK to mail to my work address

☐ OK to send a FAX ☐ OK to send to email

Communication with Other Healthcare Providers

Patient information or medical records may be communicated to other Healthcare Providers or insurance companies if necessary.

Authorization Signatures

_____ _____

Patient Signature Effective Date

or

_____ _____

Personal Representative Signature Effective Date

_____

Relationship to Patient

Communications Consent Form

Patient Name _____ Date of Birth _____

Home Phone Number _____ Cell Phone _____

Work Phone Number _____ FAX Number _____

E-mail Address _____ FAX Number _____

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply):

☐ Leave message with information.

☐ Leave message with call-back number only.

☐ Leave message at home or on the cell phone with the following individuals: (list name(s) and relationship to patient).

Name of Person to Receive Message _____

Relationship to Patient _____

Name of Person to Receive Message _____

Relationship to Patient _____

Name of Person to Receive Message _____

Relationship to Patient _____

GENERAL DENTISTRY INFORMED CONSENT FORM

*Please note that you may not need to have any of these services performed.
By signing, you acknowledged that you have read and understood the risks if you should need to have the listed services performed.*

Patient's Name: _____

↓ Please initial each statement below after reading.

_____ 1. **EXAMINATION AND X-RAYS**: I understand that the initial visit will require radiographs in order to complete the examination, diagnosis, and treatment plan.

_____ 2. **DRUGS, MEDICATION, AND SEDATION**: I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

_____ 3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

_____ 4. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

_____ 5. **FILLINGS:** I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

_____ 6. **REMOVAL OF TEETH (EXTRACTION):** Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks

involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

_____ 7. **CROWNS, BRIDGES, VENEERS AND BONDING:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

_____ 8. **DENTURES – COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

_____ 9. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

_____ 10. **PERIODONTAL TREATMENT:** I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: *I understand that dentistry is not an exact science, therefore: reputable practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurance as been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____

Why Do I Need X-rays?

Radiographic or X-ray examinations provide your dentist with an important tool that shows the condition of your teeth, its roots, jaw placement and the overall composition of your facial bones. X-rays can help your dentist determine the presence or degree of periodontal disease, abscesses and many abnormal growths, such as cysts and tumors. X-rays also can show the exact location of impacted and unerupted teeth. They can pinpoint the location of cavities and other signs of disease that may not be possible to detect through a visual examination.

Do all patients have X-rays taken every six months?
No. Your radiographic schedule is based on the dentist's assessment. In most cases, new patients require a full mouth set of X-rays to evaluate oral health status, including any underlying signs of gum disease and for future comparison. Follow-up patients may require X-rays to monitor their gum condition or their chance of tooth decay.

What kind of X-rays does my dentist usually take?
Typically, most dental patients have "periapical" or "bitewing" radiographs taken. Bitewing X-rays typically determine the presence of decay in between teeth, while periapical X-rays show root structure, bone levels, cysts and abscesses.

My dentist has prescribed a "panoramic radiograph." What is that?
A panoramic radiograph allows your dentist to see the entire structure of your mouth in a single image. This X-ray reveals all of your upper and lower teeth and parts of your jaw. It will also show any abnormal growths, such as cysts and tumors.

Why do I need both types of X-rays?
What is apparent through one type of X-ray often is not visible on another. The panoramic X-ray will give your dentist a general and comprehensive view of your entire mouth on a single film, which a Full Mouth Series, periapical or bitewing X-ray cannot show. These X-rays make it easier for your dentist to see decay or cavities between your teeth. X-rays are not prescribed indiscriminately.

Should I be concerned about exposure to radiation?
All health care providers are sensitive to patients' concerns about exposure to radiation. Your dentist has been trained to prescribe radiographs when they are appropriate and to tailor radiographic schedules to each patient's individual needs. By using state-of-the-art technology your dentist knows which techniques, procedures and X-ray films can minimize your exposure to radiation.

I accept recommended x-ray procedures

Signature_____ Date_____

If you refuse or choose to wait on x-rays in our office it is with the understanding that it is in direct opposition to my recommendations. In some cases, I may ask you to seek services at an office that would agree to treat without radiographic examination.

I decline recommended x-ray procedures.

Signature_____ Date_____

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.

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_____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name _____ Social Security Number _____

1. INSURANCE: I understand that Dr. Duncan may or may not participate with my HMO/PPO plan. We do accept assignment of benefits but you, the patient/parent, are responsible for all outstanding balance. I understand that Dr. Duncan maintains a list of health care services plans with which it contracts. A list of such plans can be discussed with the business office; and that the HMO/PPO plans that Dr. Duncan participates with are done without bias at her discretion. I understand that the extent of my benefits depends on my own contract and Dr. Duncan may or may not be participating; I have been given the opportunity to discuss my benefits regarding my health insurance policy with Dr. Duncan's office. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Dr. Duncan at the time of service.
2. RELEASE OF INFORMATION: Dr. Tiffany Duncan may disclose all or any part of my dental record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporations (1) Which is or may be liable or under contract to Dr. Duncan for reimbursement for services rendered, and (1) any health care provider for continued patient care. Dr. Duncan may also disclose on anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical educations, medical research, for the collections of statistical data or pursuant to State or Federal law statute or regulations. A copy of this authorization may be used in place of the original.
3. MEDICARE: I understand that Medicare Part A, B or C does not cover any dental procedures. I request that Medicare Part D benefits that I have be made payable on my behalf to Dr. Duncan for services furnished by Dr. Tiffany Todd Duncan. I authorize any holder of medical information about me to be released to the centers for Medicare and Medicaid services (formerly Health Care Financing Administration) and its agents, any information needed to determine these benefits of the benefits payable for related services. I understand that my signature serves as a request for payment to be made to Dr. Duncan and authorizes release of medical information necessary to pay the claim(s) that are submitted. If other health insurance is indicated in items of the HCFA 1500 Form or elsewhere on other approved claim forms, my signature authorizes releasing information the insurer or agency show. I am responsible for the deductible, co-insurance and all non-covered services. Coinsurance and deductible are based upon the charges determined by the Medicare insurer.
4. NON-COVERED SERVICES: I understand that Dr. Duncan's contracts with dental insurance plans (HMO, PPO, Fee-For-Service, etc.) relate only to items and services that are covered by the plan in which I have secured. Accordingly, the undersigned accepts full financial responsibility of all items or services, which are determined by the health care services plan and not the doctor, which are not covered. Examples of non-covered services include but are not limited to, services not specified as being covered in the patient's contract with a health care service plan, or in the benefit summary that health care service plan furnished to the patient; and treatment of tests not authorized by the health care service plan. The undersigned agrees to cooperate with Dr. Duncan to obtain necessary health care service plan authorization as needed. Failure to cooperate may result in the patient's full financial responsibility of services rendered when authorization is needed.
5. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Dr. Duncan, I will pay my account at the time services are rendered or will make financial arrangement satisfactory to Dr. Duncan for payment. If an account is sent to an attorney or collections agency, I agree to pay collection expense and reasonable attorney's fees as established by the court and not by a jury in any court actions. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance that insures the patient, or any party liable to the patient, is hereby assigned to Dr. Duncan. If co-payment and/or deductible are designated by my insurance company or health plan, I agree to pay them to Dr. Duncan. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
6. I give permission for Dr. Duncan/staff to discuss dental treatment with:

_____

_____ _____

Signature of Patient Date

Relationship to above name: _____