Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Dr. Simon Melcher & Dr. Emily Rodriguez

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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)

_____

_____

_____

Health History

Physician's Name _____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	SARS	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
			Heart Stent/Shunt	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bone Density Medications (i.e. Fosamax, Boniva, Actonel, Reclast)	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			Herpes/cold sore	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tobacco/Smokeless Tobacco	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
			Pacemaker	☐ Yes	☐ No	Sexually Transmitted Diseases	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care /Depression	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ No Known Allergies

☐ Aspirin

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Latex

☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Other _____

_____

DENTAL HISTORY

1. What is your major dental concern? _____

_____

2. Date of your last visit to a dentist? _____
3. Reason for your last visit or series of visits? _____
4. Date you last had dental x-rays taken? _____
5. Have you always had your teeth cleaned at least once a year? ..... Yes No Don't Know
6. Do you use dental floss once a day? ..... Yes No Don't Know
7. Is there fluoride in your drinking water? ..... Yes No Don't Know
8. Do you brush your teeth at least once a day? ..... Yes No Don't Know
9. Do you use toothpaste that contains fluoride? ..... Yes No Don't Know
10. Do you need to have antibiotic premedication before dental treatment? ..... Yes No Don't Know
11. Have you ever fainted during a dental visit? ..... Yes No Don't Know

    If yes, explain: _____
12. Have you experienced an unusual reaction to dental medication or anesthetic? ..... Yes No Don't Know
13 Have you experienced prolonged bleeding following dental treatment? ..... Yes No Don't Know

    If yes, explain: _____
14. Have you had any other complications following dental treatment? ..... Yes No Don't Know

    If yes, explain: _____
15. Have you had any injury to teeth, jaws or face? ..... Yes No Don't Know

    If yes, explain: _____
16. Are you happy with the appearance of your teeth? ..... Yes No Don't Know
17. Do your gums bleed when you brush your teeth or when you eat? ..... Yes No Don't Know
18. Does food or dental floss catch between your teeth? ..... Yes No Don't Know
19. Are some of your teeth becoming loose? ..... Yes No Don't Know
20. Are there spaces between your teeth now where there were none before? ..... Yes No Don't Know
21. Are any of your teeth sensitive to hot, cold or pressure? ..... Yes No Don't Know
22. Do any of your teeth ache? ..... Yes No Don't Know
23. Do you experience pain or clicking in your jaw joints? ..... Yes No Don't Know
24. Are there any sores or growths in your mouth? ..... Yes No Don't Know
25. Are you worried about receiving dental treatment? ..... Yes No Don't Know
26. Do you have any other dental concerns or complaints? ..... Yes No Don't Know

    If yes, explain: _____

    _____

SIGNATURE OF PATIENT: *I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.*

PERSON COMPLETING THIS FORM: Signature _____ Date _____

If other than patient, indicate relationship: _____

Simon P. Melcher, DDS
Emily M. Rodriguez, DDS

FINANCIAL POLICY

Thank you for choosing us as your dental provider. We are committed to your treatment being successful. This financial policy will prove helpful in determining your responsibilities for treatment.

INSURANCE AND USUAL AND CUSTOMARY FEES

Our office understands the value of insurance benefits to our patients. **We will file your insurance as a courtesy**. Please understand dental insurance is a contract between the patient and the insurance carrier. All fees including deductible and co-pay amounts are due when treatment is performed. **You are responsible for payment regardless of any insurance determination. There are no guarantees of payment from any insurance company and payment for dental services is the patient's responsibility.**

DELIQUENT ACCOUNTS

We reserve and will exercise the right to report any account 90 days delinquent to a collection agency. All expenses incurred as a result will be the patient's responsibility.

MISSED APPOINTMENTS

Appointments are valuable blocks of time. When an appointment is broken or cancelled with short notice (less than 24 hours), we are often prevented from filling that time and helping other patients. **We will charge a $75 non-refundable fee for all appointments broken or cancelled with less than 24 hours notice (unless special circumstances prevail).**
**** The first broken appointment will be a courtesy notice – the second broken appointment shall be charged. ****

I have read and understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsibly Party **Date**

INFORMED CONSENT FOR LOCAL ANESTHESIA

This consent form is designed to make you aware of the risks involved with local anesthetics. The risks include, but are not limited to:

A) There are risks of anesthesia that may affect your body, such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate or various types of allergic reactions. Any or all of these may require additional medical management or hospitalization.

B) Restricted mouth opening during recovery sometimes related to muscle soreness at the site of the injection requiring physical therapy.

C) Local anesthetic may cause prolonged numbness in some patients that may result in injury from biting or chewing an area such lip cheek or tongue that has received the local anesthetic.

D) Injury to nerves that can result in pain, numbness, tingling or other sensory disturbances to the chin, lip, cheek, gums or tongue. This may persist for several weeks, months and may rarely be permanent.

E) Local anesthesia is administered with a very small fine needle. In very rare instances these needles may break off and be lodged in soft tissue.

Please ask the dentist if you have any questions regarding this consent form. Do not initial or sign any blank if you have not had your questions answered.

I hereby acknowledge that I have read this document and I have discussed all questions or concerned that I might have regarding local anesthesia.

Patient Signature_____Date_____

Witness_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Simon P. Melcher, DDS and Emily Rodriguez, DDS
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. If you have any questions about this Notice please contact the Privacy Officer.

Cathy Davenport @ Raleighdds@hotmail.com

Effective Date: April 14, 2003 Revised: Oct 26, 2016

We are committed to protect the privacy of your personal health information (PHI).
This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **(www.theraleighdentists.com)**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your dentists, 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.
EXAMPLE: Your PHI may be provided to a dentist or specialist to whom you have been referred For evaluation to ensure that the practitioner has the necessary information to diagnose or treat You. We may also share your PHI from time-to-time to another dentist or health care provider (e.g., a specialist or laboratory) who, at the request of your dentist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your dentist.
We may also share your PHI with people outside of our practice that may provide medical care For you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:
- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services Such as x-rays to your insurance company so that we can get paid for the procedure. We may at times Contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:
 Training students, other health care providers, or ancillary staff such as billing personnel to Help them learn or improve their skills.
 Quality improvement processes which look at delivery of health care and for improvement in Processes which will provide safer, more effective care for you.
 Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:
 If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report Gunshot wounds or suspected abuse or neglect.
 Public health activities: The disclosure will be made for the purpose of controlling disease, Injury or disability and only to public health authorities permitted by law to collect or receive Information. We may also notify individuals who may have been exposed to a disease or may Be at risk of contracting or spreading a disease or condition.
 Health oversight agencies: We may disclose protected health information to a health oversight Agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the Health care system, government benefit programs, other government regulatory programs and Civil rights laws.
 Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain Conditions in response to a subpoena, or other lawful process.
 Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
 Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
 Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
 Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
 Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
 Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.
Business Associates: Some services are provided through the use of contracted entities called

“business associates”. We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.
Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.
 We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
 We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
 We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:
 Marketing
 Disclosures of for any purposes which require the sale of your information
All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.
Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights
You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Please request a form from our front desk or submit your request to the Privacy Officer by email at top of document.

You have the right to see and obtain a copy of your protected health information.
This means you may inspect and obtain a copy of protected health information about you that is

- Contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.
You may request for this practice not to use or disclose any part of your protected health

information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.
We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.
You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights
 You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
 You have a right to receive notification of any breach of your protected health information.

Complaints
If you think we have violated your rights or you have a complaint about our privacy practices you can contact:
Privacy Officer: Cathy Davenport, email raleighdds@hotmail.com
You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.
If you file a complaint we will not retaliate against you for filing a complaint.
This notice was published and becomes effective on April 13, 2003 and was revised on Oct 26, 2016