Adam J. Frieder, DDS, LLC
Frederick Dental
401 West 7th Street
Frederick, Maryland 21701
(301)662-7766
www.friederdental.com

Office Policy

In order to keep our operating costs down which in turn will enable us to continue to provide our patients with excellent care at competitive fees, we must ask that you respect our policies.

- Appointments cancelled with less than 48 hours notice and cannot be filled with another patient, will incur a charge of $50.00, since this time is reserved just for you.
- Patients who do not keep their appointment, and do not notify the office, will incur a charge of $50.00, since this time is reserved just for you.
- So we can better prepare for lengthy procedures, appointments that will be scheduled for over 60 minutes will require a non-refundable retainer. This fee will be 1/2 of the estimated co-payment for that particular procedure. The retainer will be applied to your dental treatment. (minimum retainer no less than $100.00).
- Unfortunately, some procedures may require additional costs that may not be covered by your insurance carrier. These costs are the patient's responsibility and will be discussed prior to treatment.
- We are trying to "go green" by eliminate mailing statements as much as possible. In order to do this, please allow us to apply the balance, not paid by your insurance, to be charged to your credit card on file.

We are committed to providing the best treatment to our patients and we appreciate your understanding. Thank you for your cooperation.

I have read and agree to the above: _____ Date: _____
(Patient's signature)

Adam J. Frieder, DDS, LLC

401 W. Seventh St., Frederick, Md. 21701 (301) 662-7766

We'd like to get to know you better! Date_____

PERSONAL INFORMATION

Patient Name_____ Nickname_____ Sex_____

Birth date_____ Social Security #_____-____-_____ Occupation_____

Person Responsible for Account _____ Relationship _____

Social Security #_____-____-_____ Birth date_____ Driver's License #_____

Patient Address_____

Billing Address_____

Home Phone _____ Business Phone _____

Mobile Phone _____ E-Mail Address _____

Responsible Party's Phone_____ Referred by _____

From the phone numbers above, please circle the best one for us to reach you during the daytime.

EMPLOYER AND INSURANCE INFORMATION

Please provide office with a copy of your insurance card.

Name of primary insurance holder_____ Relationship_____

Insurance Company _____ Group #_____

Ins. Co. Phone _____ Ins. Co. Address_____

MEDICAL HEALTH

Name and address of physician_____
Phone # of physician _____
Have you been under a physician's care during the past 2 years? _____
For_____
Have you been treated in the hospital in the last two years? _____
For _____
Have you ever had major surgery? _____
If female, are you on hormones or birth control? ___ Are you pregnant or nursing? _____
Have you ever had a blood test for hepatitis? ____ Were you vaccinated? _____
Have you ever had canker or cold sores on your lips, tongue, gums or body? _____
Are you now taking, or have you taken any prescription drugs during the past year? _____
Please list: _____
_____
Are you allergic to? _____Penicillin _____Codeine _____Local Anesthetics ____Latex
Allergies to Other Medications _____
Have you been out of the country within the last two years? _____

Have you had, or do you now have:

	Yes	No		Yes	No
High/low blood pressure	___	___			
AIDS	___	___	Herpes	___	___
Allergies	___	___	Jaundice	___	___
Anemia	___	___	Joint Replacement	___	___
Angina	___	___	Kidney Disease	___	___
Arthritis	___	___	Liver Disease	___	___
Artificial heart valves	___	___	Organ Transplant	___	___
Artificial joints	___	___	Pacemaker	___	___
Asthma	___	___	Prolonged bleeding	___	___
Cancer	___	___	Prolonged cough	___	___
Chemotherapy	___	___	Psychiatric treatment	___	___
Congenital heart lesions	___	___	Radiology therapy	___	___
Diabetes	___	___	Rheumatic fever	___	___
Drug Dependency	___	___	Sickle Cell Anemia	___	___
Easily bruised	___	___	Sinus/Hay Fever	___	___
Epilepsy/Neurological problems	___	___	Stroke	___	___
Fainting or dizzy spells	___	___	Thyroid Disease	___	___
Glaucoma or eye problems	___	___	Tonsillitis	___	___
Heart disease	___	___	Tuberculosis/Lung disease	___	___
Heart murmur	___	___	Ulcers	___	___
Hepatitis	___	___	Venereal Disease	___	___

Have you any disease, condition, or problem not previously listed? _____

_____

DENTAL HEALTH

When was your last dental visit? _____ Who did you see? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort:

Hot___ Cold___ Sweets___ Chewing___

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

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Does it ever click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you have frequent headaches? _____ Ear aches? _____

Have you ever had orthodontic treatment (i.e. braces?)_____ When? _____

Do you lose or break fillings?_____ Do you usually have many cavities? _____

Do you have any loose teeth? ____Cracked or broken teeth? _____Food traps? _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? ___Fixed bridge ___Removable Partial ___Full denture ___Implant

Are you comfortable with the replacement? Please describe _____

_____

Do you have an unpleasant taste or odor in your mouth? _____ Do you smoke? _____ How much?_____
Do you frequently snack between meals or chew gum? _____ Have you ever been instructed regarding proper home care? _____Has fear or discomfort kept you from regular dental visits? _____
Is there anything you would like to share with us that we have not mentioned? _____
_____

PERSONAL SMILE EVALUATION

Please take a moment to answer these questions about your smile:

1) On a scale of 1-10 (1 being the lowest), rate your teeth and smile_____
2) Are your teeth crooked, crowded or worn? If so, are you concerned? _____
3) Do you have any spaces between your teeth that bother you? _____
4) Do you like the color of your teeth? _____
5) Have you ever considered how you'd feel with a brighter smile? _____
6) Do you like the shape of your teeth? _____
7) What changes would you like to make with the appearance of your smile? _____
   _____
8) Is there anything you'd like to share with us that we have not mentioned? _____
   _____

If we may assist you or answer any concerns you may have—please ask! We want to make your dental experience as pleasant as possible!

The above information is true and complete to the best of my knowledge. I consent to the treatment requested by me covering all aspects of routine dental care, including administration of x-rays, photos, local anesthetics, sedatives, nitrous oxide or combination. I consent to have an HIV or hepatitis test paid for by Dr. Frieder should any accidental exposures to any of the clinical personnel occur. I understand that perfect results cannot be guaranteed.

Signature_____ Date _____

CONSENT FORM FOR HYGIENE

I agree to occasionally receive dental hygiene services without a dentist in the office if I have been examined by Dr. Frieder within the past seven months. I understand a prescription for these services is written in my chart

Signature of Patient _____ Date _____

Signature of Hygienist _____ Date _____

Consent for a Minor or Incompetent Adult

I, _____, as custodial parent or guardian of _____, consent to the occasional delivery of hygiene services to _____ without a dentist present if she/he has been seen by Dr. Frieder within the last seven months. I am aware that a prescription for dental hygiene services is written in the patient's chart.

Signature of Parent/Guardian: _____ Date _____

Signature of Hygienist: _____ Date _____

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may—but are not required to—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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. 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.

Provider Contact Office: Office Manager

Telephone: (301) 662-7766 Fax: (301) 662-7776

E-Mail:

Address:

Frederick Dental Adam J. Frieder, DDS, LLC
[Insert Name of Practice]

NOTICE OF PRIVACY PRACTICES

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 PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

Adam J. Frieder, DDS, LLC
Frederick Dental
Family and Cosmetic Dentistry

Credit Card Payment Authorization Form

Sign and complete this form to authorize Adam J. Frieder, DDS, to make a debit to your credit card listed below.

Please complete the information below:

I authorize the office of Adam J. Frieder, DDS, to charge the balance due after the insurance carrier has paid their portion of the claim for dental work rendered.

Patient: _____ **Date:** _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.