PATIENT INFORMATION

PLEASE PRINT THE FOLLOWING INFORMATION

PATIENT _____ **AGE**_____

O CHILD O SIMGLE O MARRIED O DIVORCED O WIDOWED O SEPARATED

HOME ADDRESS _____

CITY_____ **STATE** _____ **ZIP**_____

HOME PHONE_____

IP PATIENT IS A MINOR, NAME OF RESPONSIBLE PARENT _____

PATIENT OR PARENT EMPLOYED BY _____

BUS PHONE_____

BUS ADDRESS_____ **OCCUPATION**_____

NAME OF SPOUSE_____ **OCCUPATION**_____

BUS. ADDRESS_____ **BUS PHONE**_____

BIRTHDATE _____ **SOC SEC #** _____

DENTAL INS. PLAN _____

REFERRED BY _____ **PHYSICIAN** _____

Health Questionnaire

1. **What is your present dental problem**?_____

(a) **Date of last exam**_____

(b) **What services were done**_____

(c) **When x-rays last taken**_____

(d) Have you ever had periodontal (gum) treatment? ——————————— NO YES
(e) Have you ever worn braces? ——————————————————————-——— NO YES
(t) Are your teeth sensitive to hot or cold? _____NO YES
(g) Do your gums bleed easily? ——————————————————————-— NO YES

2 Have you had an unusual reaction to any drugs or medicines? ——————— NO YES
To What? i.e. Penicillin _____
3 Is your physician treating you now? _____ NO YES
4. Are you taking any medicines or tablets? ——————————————————— NO YES
What? _____
5 Have you taken cortisone or steroids? _____ NO YES
6 Have you any allergy? _____ NO YES
7 Are you a bleeder or bruise easily? _____ NO YES
8. Do you faint easily?_____ NO YES
9. Have you heart disease or murmur? _____ NO YES
10. If a female, are your pregnant? _____ NO YES
11. Do you smoke? _____ NO YES

12 **Do you have or have you had? Circle**.

Heart trouble Diabetes Blood disorders
High blood pressure Epilepsy Anemia
Rheumatic fever Thyroid trouble Hepatitis
Kidney trouble Tuberculosis Venereal disease
Liver trouble Asthma HIV Stroke
Pacemaker Sinus trouble Any others _____

13. **Before treatment can be rendered, adequate radiographs of the teeth and mouth may be taken.**

OFFICE POLICY

a) Payment for professional services Is required on the day treatment Is rendered.
b) Your appointment time is reserved especially for you, so there must be a charge for appointments not cancelled 24 hrs.in advance.

This is to certify that the above information I have given is correct and current and I agree to accept full responsibility for the payment of all fees associated with the examination and/or treatment

Patient (Parent) _____ Date_____

OUR FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to your treatment being successful. Please understand that the payment of your fees, and the keeping of your appointments, is an integral part of your relationship with us. Therefore, to avoid any misunderstandings, or miscommunications, the following is a statement of our financial policy. We ask that you read it carefully, and sign and acknowledge it before commencing with treatment.

PAYMENTS

We accept cash, checks, and credit cards (Visa, MC, and Discover). On extensive treatments we also can provide financing with dental healthcare finance company. We request that payment be made at the time of your office visit when treatment is rendered. For those patients that have insurance, as a courtesy to you, we will wait for your insurance to pay its <u>estimated</u> share. We cannot be responsible if your company chooses not to pay, for whatever reason, the amount we have estimated. We ask that you pay any deductible and co-payment at the time of treatment. Also, we cannot properly bill your insurance company unless you give us correct and current insurance information. If your account is not paid in full by your insurance company within 30 days, you will then be billed for the balance. Appointments must be cancelled 24 hours in advance, otherwise, a charge will be assessed.

ABOUT YOUR INSURANCE

Your insurance policy is a contract between you and your insurance company. You are responsible to know the provisions of your policy. As your dental care provider, we perform the care we feel is necessary and correct, and has been agreed upon between the doctor and the patient. In no way can we let an insurance company dictate what is proper dental care. We are involved with hundreds of insurance companies, and thousands of patients, and cannot know the details of each individual policy, which can vary from employer to employer. We will try our best to be helpful, but we cannot take the responsibility of interpreting and educating patients about their policies. We will, however, fill out all claim forms for you, and will wait for your estimated share for a reasonable period of time. The only exception to that are Assistance type insurance plans. Thank you for your cooperation and understanding. An informed patient is our best asset, so together we will have a successful result.

I have read and understand the above financial policy statement of Hagen Dental, and am financially responsible for payment of services to Dr. Ronald M. Hagen.

___/ ___/ _____ _____

Date **Patient's signature**

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.) We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Ronald M. Hagen D.D.S., P.A.

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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003), 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 changes are permitted by applicable law. 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 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: 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. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use 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 must disclose your health information to you. as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of(including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

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 obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.2.00 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will 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 a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

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).

Alterative 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.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. 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.

Contact Officer: Dr. Ronald M. Hagen

Telephone: 305-667-4410 Fax: 305-667-8492

E-mail: drhagen@hagendental.com

Address: 8257 S. Dixie Hwy., Miami, FL 33143

Ronald M. Hagen D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received and read 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)

_____

_____

Ronald M. Hagen D.D.S., P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Elizabeth or Dr. Ronald Hagen

Telephone: 305-667-4410_____ Fax: 305-667-8492.

E-mail: drhagen@hagendental.com

Address: 8257 S. Dixie Hwy., Miami. FL 33143.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will nor affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE:

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name. _____

Relationship to Patient: _____