CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name:____ Date of Birth: ________________________________

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. 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, 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 requesting it from us or print the online version.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we will 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 as described in the “Notice of Privacy Practices.”

Legal Guardian’s Signature ____ Date______________________

ASHEVILLE PEDIATRIC DENTISTRY FINANCIAL POLICY

Thank you for choosing our office to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these explanations of payment for services:

1. **Payment:**
   a. Payment is due in full by cash, personal check, or charge card at each appointment as services are rendered.
   b. We accept Master Card, Visa, and Discover.
   c. A charge of $30.00 will be assessed on checks returned for any reason. After two incidents of returned checks, we will no longer accept checks.
   d. Any unpaid balance over 30 days will be subject to a finance charge of 18% APR.

2. **Dental Insurance:**
   a. Dental insurance is a contract between your employer and the insurance company. We cannot influence how much of our fees your insurance will cover. Your benefits are determined by the policy your employer purchased.
   b. As a courtesy, our office will file your child's dental insurance.
   c. Please be aware that the person bringing the child for dental care is legally responsible for payment of all charges.

3. **Pretreatment Authorization:**
   a. Some insurance companies request an estimate of the work to be done and the fees to be charged before determining their benefits to you (i.e., Impacted Canine Exposure).
   b. We will give you an estimate of necessary treatment and our fees which you may convey to your insurance company.
   c. It will be up to you to determine if you wish to proceed with treatment before the insurance benefit is determined.

4. **Fillings:**
   a. We offer white fillings (composite resins) and silver fillings (amalgams).
   b. Please understand that some insurance companies do not pay for a white filling (composite resin) at the same level as a silver filling (amalgam).
   c. In some cases, when the cavity is too large to be restored with a composite resin, the tooth will need to be crowned
      i. We use silver-colored stainless steel crowns.
      ii. If the tooth requires nerve treatment (pulpotomy or pulpectomy), the tooth will need to be crowned with a stainless steel crown.

5. **Nitrous Oxide:**
   a. Nitrous oxide is an inhalational sedation technique often used by pediatric dentists.
      i. Nitrous oxide is a slightly sweet smelling inert gas that induces a sense of well- being and relaxation.
      ii. It is very safe, perhaps the safest sedative agent in dentistry.
      iii. It is non-addictive. It is mild, easily taken, and then quickly eliminated by the body.
      iv. Your child remains fully conscious, keeps all natural reflexes, when breathing nitrous oxide/oxygen.
      v. Nitrous oxide is not always covered by dental insurance.

6. **Oral Sedation:**
   a. Conscious sedation is a management technique that uses medications to assist the child to cope with fear and anxiety and cooperate with dental treatment

   b. Who should be sedated?
      i. Children who have a level of anxiety that prevents good coping skills or are very young and do not understand how to cope in a cooperative fashion for the delivery of dental care should be sedated.
      ii. Conscious sedation is often helpful for some children who have special needs.
   c. Oral sedation is not always covered by dental insurance. We thank you for the payment the day you schedule your child's oral sedation appointment.

7. **Appliances:**
   a. The cost of the appliance (space maintainer) is due the day the impression is taken. This is necessary because our office must pay for the lab fees when appliances are ordered, not when they are completed.
   b. Space maintainers are not always covered by dental insurance.

8. **Emergency Treatment:**
   a. All emergency treatment must be paid in full at the time the service is rendered.
   b. If an emergency occurs after normal business hours, an "After Hours Office Visit Fee" will be charged.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation is greatly appreciated!

I have read and understand my financial obligation to Asheville Pediatric Dentistry.

Legal Guardian's Signature____Date:____________________________

ASHEVILLE PEDIATRIC DENTISTRY APPOINTMENT INFORMATION

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call our office **at least 24 hours** in advance so that we may give that time to another patient.

- One parent is welcome back for their child's dental visit. The exception is during conscious sedation appointments, where we ask that the parent waits in the reception area.

- *All restorative (fillings, extractions, etc.) procedures for young children are scheduled in the morning.* Children, as well as adults, are more prepared and do better in the morning for these types of procedures.

- We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.

- *If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.*

- Broken or missed appointments affect many people. If a broken/missed appointment occurs or a cancellation without 24-hours notice, our office reserves the right to NOT schedule any subsequent appointments and/or charge a broken appointment fee.

- *A parent or legal guardian (with official documentation) must be present during all appointments that the child patient is in the office.*

I have read and understand the appointment information.

Legal Guardian's Signature____Date:____________________________

Asheville Pediatric Dentistry

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.
Privacy Officer contact number (828) 277-6788

Effective Date: October 25, 2007 **Revised: January 1, 2015**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices 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.ashevillepedo.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 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.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

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.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

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

<u>All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.</u>

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.

<u>Your Privacy Rights</u>

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

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:

Asheville Pediatric Dentistry
76 Peachtree Rd, Ste 100
Asheville, NC 28803
(828) 277-6788

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 October 25, 2007

X____

Parent/Legal Guardian Signature Date

Authorization to Release Health Information

Name of Patient: ________________________________ Date of Birth: ______________________

Address: ____

City, State, Zip: _________________________________ Phone: ___________________________

I request and authorize ____ to release health information of the patient named above to:

Name: ______________Asheville Pediatric Dentistry______________________________

Address: ___________76 Peachtree Rd, Suite 100_____________________________

City: _______________Asheville____State: __NC___ Zip Code: __28803______________

Phone: __828-277-6788___________ Email: __mailbox@ashevillepedo.com__________

The following information is requested:

____ Most current x-rays ____ All x-rays ____ Treatment and Care Summary

____ Healthcare information relating to the following treatment, condition, or dates:

____

____ Other: ____

Patient Information I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.* I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward. I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to ____.

Signature of Patient or Parent/Legal Guardian: ______________________________ Date: _____________

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL THE INFORMATION HAS BEEN FORWARDED AS REQUESTED.