Pro Solutions Dental Group
FAMILY, IMPLANT, & RECONSTRUCTIVE DENTISTRY

INFORMATION REQUIRED FOR CASE HISTORY RECORDS
This complete confidential record is important for our records and your health.
THIS FORM MUST BE FULLY COMPLETED.

1 PATIENT INFORMATION & MEDICAL HISTORY

Patient's Name _____ Email Address _____
Mr. /Mrs. /Ms. (Circle one) _____ Spouse/Parent Name _____
Mailing Address _____ City, State, Zip _____
Patient's Social Security # _____ - _____ - _____ Date of Birth _____
Home Phone _____ Cell Phone _____ Work Phone _____
Whom may we thank for referring you to us? _____
Your Employer _____ Work Phone _____
Emergency Contact _____ Phone _____
Physician _____ Phone _____

PLEASE COMPLETE THE FOLLOWING INFORMATION IF PATIENT IS COVERED BY DENTAL INSURANCE:
Name of Ins. Co. _____ Group # _____
Employee _____ Employee ID/ SSN _____
Employer _____ Employee DOB _____

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Pro Solutions Dental Group to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Pro Solutions Dental Group. I permit a copy of this authorization to be used in place of the original. I give Pro Solutions Dental Group, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

SIGNATURE_____ **DATE** _____ / _____ / _____

DOES DENTAL TREATMENT MAKE YOU NERVOUS? No ☐ Slightly ☐ Moderately ☐ Extremely ☐
Why are you now seeking dental treatment? _____

PLEASE ANSWER EACH QUESTION. CIRCLE YES OR NO. IF IN DOUBT, LEAVE BLANK.

1. Are you in good health now?.....YES _____ NO _____
2. Are you under the care of a physician? YES _____ NO
   If so, what is the condition being treated? _____
3. Have you been hospitalized or had a serious illness within the last 5 years?.....YES _____ NO _____
   If so, list. _____
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?.....YES _____ NO _____
5. (Women) Are you pregnant? YES ___ NO ___ If so, please give due date. _____
6. Do you use tobacco in any form?.....YES _____ NO _____
7. Do you need to be pre-medicated with antibiotics before dental appointments? .....YES _____ NO _____
8. Do you have a history of alcohol, recreational or prescription drug misuse?.....YES _____ NO _____

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

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DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

SKIN	YES	NO
Eruptions (rash) Hives	___	___

URINARY	YES	NO
Kidney Disease	___	___
Sexually Transmitted Diseases	___	___
Specify Type	___	___

EARS	YES	NO
Ringing in ears	___	___

RESPIRATORY	YES	NO
Tuberculosis	___	___
Emphysema	___	___
Asthma / Hayfever	___	___

HEART/BLOOD VESSELS	YES	NO
Rheumatic Fever	___	___
Heart Murmur	___	___
Chest Pain / Discomfort	___	___
Heart Attack	___	___
High Blood Pressure	___	___
Congenital Heart Disease	___	___
Artificial Heart Valve	___	___
High Cholesterol	___	___
Pacemaker / Defibrillator	___	___
Heart Surgery / Angioplasty	___	___
Mitro Valve Prolapse	___	___

BONE / MUSCLE	YES	NO
Artificial Joints	___	___
Arthritis: **RA** **DA**	___	___
Implants	___	___
Specify Type	___	___

DIGESTIVE SYSTEM	YES	NO
Acid Reflux	___	___
Gerd	___	___

BLOOD	YES	NO
Hepatitis: **A** **B** **C**	___	___
Jaundice	___	___
Anemia	___	___
Blood Transfusion	___	___

MOUTH	YES	NO
Clicking / Popping Jaw	___	___
Difficulty Opening / Closing Jaw	___	___
Do you use a Fluoride rinse?	___	___
Halitosis (Bad breath)	___	___

NOSE	YES	NO
Sinus Problems	___	___

THROAT	YES	NO
Chronic Soreness / Hoarseness	___	___

NERVOUS SYSTEM	YES	NO
Stroke	___	___
Convulsions / Epilepsy	___	___
Numbness / Tingling	___	___
Dizziness / Fainting	___	___

ENDOCRINE	YES	NO
Diabetes: **Type 1** **Type 2**	___	___

OTHER	YES	NO
Radiation Therapy / Chemo	___	___
Tumors / Growths	___	___
Cancer	___	___
AIDS / HIV +	___	___
Autoimmune Disease	___	___

ARE YOU ALLERGIC TO, OR HAVE YOU EVER HAD A REACTION TO ANY OF THE FOLLOWING?	YES	NO
Local Anesthetic (Novocaine)	___	___
Barbiturates, Sedatives	___	___
Penicillin / Antibiotics	___	___
Sulphur or Sulphuric drugs	___	___
Aspirin	___	___
Codeine	___	___
Latex Allergy	___	___
Other	___	___

ARE YOU CURRENTLY TAKING, OR HAVE YOU RECENTLY TAKEN ANY OF THE FOLLOWING?	YES	NO
Tranquilizers	___	___
Insulin / Other Diabetic Drugs	___	___
Digitalis / Heart Medication	___	___
Nitroglycerin	___	___
Cholesterol	___	___
Aspirin-Daily	___	___
Antibiotics / Sulfa	___	___
Blood Thinners	___	___
Blood Pressure Medicine	___	___
Thyroid Medicine	___	___
Phenphen / Redux	___	___
Cortisone or Steroids	___	___
Other Medication	___	___

IF YES TO ANY OF THE ABOVE, PLEASE LIST NAME OF MEDICATION AND DOSAGE.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Any other health conditions we should be aware of? _____

_____

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I have read, understood, and agree to the above treatment policy.

SIGNATURE_____ **DATE** _____ / _____ / _____

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2 REFERRAL INFORMATION

Where did you hear about us? Please Check ALL that apply & specify.

- ☐ Friend or Relative (name): _____
- ☐ Referred by Provider: _____
- ☐ Search Engine (Google, etc.): _____
- ☐ Paper/Other Publication Ad/Article_____
- ☐ Other Website_____
- ☐ Seminar Attendee Topic: _____Presenter:_____Date: _____
- ☐ Other: _____
- ☐ Drive By
- ☐ Facebook
- ☐ PrescottDentist.com Website
- ☐ Radio Ad _____
- ☐ Phone Book _____

3 CANCELLATION POLICY

We strive to provide our patients with the utmost professional and excellence of service. Our commitment to your wellbeing is something everyone in our office takes seriously. Because we care about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need. When you reserve time on our schedule, you will receive either an appointment card or a billing statement with your reserved date and time for your services. As a courtesy, an attempt to contact you with a reminder will be made 24 to 48 hours prior to your reserved time. With the exception of serious emergencies it is expected that you keep your reserved appointment time. If you need to reschedule a reserved time, **we require 24 hours notice.** In the instance of a cancellation without 24 hour notice or you fail to show for your reserved appointment time, a $40.00 reservation fee will be charged to your account. In the instance of repeated non-compliance or failure to cover broken appointment fees we reserve the right to discontinue care in this office.

I have read and understand this Cancellation Policy, and any questions I may have had concerning this policy have been addressed.

SIGNATURE_____ **DATE** _____ / _____ / _____

4 PAYMENT POLICY

Thank you for taking the time to understand our provided **Payment Policy**. For any questions about fees, financial policies, or your responsibilities, please refer to the Payment Policy and/or contact our front office staff.

Payment Options

We accept cash, check, Discover, MasterCard and Visa. Check payments require a valid photo ID. Acceptable ID include a state or military ID.

For convenience financing options are available through CareCredit® patient payment plans, providing:

- Flexible financing options
- Convenient low minimum monthly payments
- No annual fees or prepayment penalties
- Immediate credit decision

CareCredit® can be an excellent financial solution for your care needs. Restrictions may apply. Our front office team is available to assist you with CareCredit's® online application and approval process.

Payment for Minors

The attending adult bringing a child for treatment is responsible for payment at time of service. A divorce decree does not supersede our policy for payment. Our billing system does not accommodate billing two separate parent accounts for payment.

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Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance is to be paid by you at the time of service.

Having a secondary insurance does not guarantee that services will be covered 100%. Your dental insurance plan is a contract between you, your employer, and the insurance company. It is the patient's responsibility to understand the provision benefits and restrictions of the policy.

Please notify our office of any changes in the insurance company, policy number, or coverage. This will help keep your information current, and will assist in prompt insurance payments. Also, advise our front office of any insurance claims that have incurred prior to visiting our office as these claims may affect your estimated amount owed, and remaining coverage.

As a courtesy, our office will file all applicable insurance forms. Please note that our front office will calculate as closely as possible the difference estimated to be your responsibility. Although we strive to provide an accurate estimate of your portion due, such information is NOT a guarantee of payment or eligibility with your insurance company and is ONLY an estimate. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. Reduction or rejection of your claim by insurance does not relieve you of financial obligation with our practice.

Payment for co-payments, non-covered services and deductibles' are due at time of service. Any balance due after your claim has been settled is due upon invoice receipt.

Returned Checks

Personal checks that are returned due to "insufficient funds" are turned over to the Yavapai Country Attorney's office. If not paid upon notification, the account(s) will be turned over to collections and charged a $25.00 service fee per account. Appointments for care will be suspended until account(s) is in good standing.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.50 for a minimum balance of $25.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. **Please be advised that there is a $40.00 fee charged for missed or broken appointments without 24 hours notice. To avoid this charge, kindly give us a minimum of 24 hours' notice for any appointment cancellation.** Feel free to contact us at any time with questions you may have.

Authorization

Patient Name: _____

I have read and understand the above Payment Policy. I hereby authorize payment directly to Jason C. Campbell DDS PLLC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grand the right to Jason C. Campbell DDS PLLC to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

SIGNATURE_____ **DATE** _____ **/** _____ **/** _____

5 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 the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- 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 healthcare or with payment for your healthcare. 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.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for adults by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else

- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 11, 2016, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to use or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, call or visit our office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.D. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

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HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Pro Solutions Dental Group to use and/or disclose my protected health information to carry out the following:

Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.

Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.

The day-to-day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

SIGNATURE_____ **DATE** _____ / _____ / _____

If signing on behalf of someone, explain your relationship to the patient: _____

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form: _____

_____

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

Office Personnel Signature: _____ Date: _____ / _____ / _____

Office Personnel Name: _____ Office Personnel Title: _____

Oral Cancer Exam

Our dental practice continually looks for advances to ensure that we are providing the optimum level of oral healthcare to our patients. We are concerned about oral cancer and look for it in every patient. One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause of increasing incidence and mortality rates from oral cancer. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors, but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV 16/18) plays a role in more than 20% of oral cancer cases. Oral cancer risk by patient profile is as follows:

INCREASED RISK: Patients age 18-39, sexually active patients (HPV 16/18)

HIGH RISK: Patients age 40 and older, tobacco users (ages 18-39, any type within 10 years)

HIGHEST RISK: Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

Please select one:

☐ YES – I would like to have the oral cancer exam.

☐ NO – I would prefer not to have the oral cancer exam at this time.

SIGNATURE_____ **DATE** _____ / _____ / _____

6 DENTAL HISTORY

Previous Dentist

Dentist Name: _____ Dental Practice Name: _____ Phone: _____
Address: _____ City: _____ State: _____ ZIP Code: _____
What did you like about your last dentist? _____
What caused you to leave your last dentist? _____

Last Dental Visit

Last Dental Visit (m/y): _____ / _____ What were you treated for? _____
Treatment Complete? Yes ☐ No ☐ What was done at your last dental visit? _____
Last X-Rays: _____ / _____ Last Full-Mouth X-Rays: _____ / _____ Last Cleaning: _____ / _____

Dental Hygiene

How often do you visit a dentist? _____
Do you brush your teeth? If yes, how often? _____
Do you floss? If yes, how often? _____
Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use: _____
Are you interested in regular hygiene cleanings? _____

Miscellaneous

Has fear ever been an issue for you in a dental office? Yes ☐ No ☐
Has time ever been a factor in getting your dental work done? Yes ☐ No ☐

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe: _____

What is the main reason for your visit today?

☐ Tooth Pain ☐ Check-up ☐ Cleaning ☐ Whitening ☐ Cosmetic Dentistry
☐ Sedation Dentistry ☐ Missing Teeth ☐ Restorative Dentistry ☐ Other _____

What would you like to learn more about?

☐ Whitening ☐ Implants ☐ Bridges ☐ Veneers
☐ Sedation Dentistry ☐ Dentures ☐ Cosmetic Dentistry ☐ Other _____

Dental Concerns – *check all that apply*

TEETH

☐ Broken or chipped ☐ Loose/missing filling ☐ Missing teeth ☐ Sensitive to sweets
☐ Crooked ☐ Loose teeth ☐ Mouth sores ☐ Blisters on lips/mouth
☐ Decay ☐ Sensitive when biting ☐ Sensitive to cold ☐ Orthodontic treatment
☐ Difficulty chewing ☐ Food trap areas ☐ Sensitive to heat ☐ Bad taste in mouth
☐ Discolored ☐ Grinding or clenching ☐ Tooth pain

GUMS

☐ Bad breath ☐ Abscessed ☐ Sore ☐ Receding
☐ Red (discolored) ☐ Bleeding ☐ Swollen ☐ Periodontal treatment

FACIAL/JAW PAIN

☐ Frequent headaches ☐ Pain in temples ☐ Jaw injury ☐ Jaw locks open/closed
☐ Avoid certain foods ☐ Pain around ear ☐ Head injury
☐ Popping/clicking ☐ Pain in jaw ☐ Neck injury

7 PATIENT IMAGE RELEASE AND CONSENT FORM

Pro Solutions Dental Group stores images of prior restorations we have created should the need to create additional restorations for a patient arise. We will occasionally use images of restorations created by our office on our website or in brochures promoting our business. Unless express permission is provided by the patient, these images are almost always restricted to images of only the smile area with random numbers assigned to the case for identification purposes. **We would like your permission to use your smile image**. Please check appropriate boxes indicating your consent and sign below. Thank you.

I, the undersigned, do hereby consent and agree that Pro Solutions Dental Group, its employees or agents have my consent to take photographs, videotape, or digital recordings of me ☐ (Please Check If Appropriate) or only my dental restorations and limited to my smile ☐ (Please Check If Appropriate) or of my child, Relationship to child? _____ and to use these in any and all media, now or hereafter known, and exclusively for the purpose of reference for future restorative work or building the portfolio of this office and/or any business associated with Pro Solutions Dental Group and/or for any promotional material printed or virtual such as brochures or the website of Pro Solutions Dental Group.

I further consent that my name and identity may be revealed therein ☐ (Please Check If Appropriate) or may be used only by descriptive text or commentary excluding my name or identity or likeness in whatever media used.

I do by hereby release to Pro Solutions Dental Group, its agents, and employees all right to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback. I also understand that Pro Solutions Dental Group is not responsible for any expense or liability incurred as a result of my participation in this recording.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____ Date: _____

Contact Information: _____

Witnesses for the Undersigned: _____ Dentist's Name: _____

Patient's or Representative's Signature: _____

8 ADDITIONAL

OFFICE USE ONLY

OFFICE BLOOD PRESSURE BASELINE: _____

Any changes? ☐ YES ☐ NO List: _____ INITIAL _____ DATE _____
Any changes? ☐ YES ☐ NO List: _____ INITIAL _____ DATE _____
Any changes? ☐ YES ☐ NO List: _____ INITIAL _____ DATE _____
Any changes? ☐ YES ☐ NO List: _____ INITIAL _____ DATE _____
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www.PrescottDentist.com

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Having a secondary insurance does not guarantee that services will be covered 100%. Your dental insurance plan is a contract between you, your employer, and the insurance company. It is the patient's responsibility to understand the provisions, benefits and restrictions of the policy.

Please notify our office of any changes in insurance company, policy number, or coverage. To keep your information current, and will assist in prompt insurance payments. Also, advise our front office of any insurance claims that have incurred prior to visiting our office as these claims may affect your estimated amount owed, and remaining coverage.

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Personal checks that are returned due to “insufficient funds” are turned over to the Yavapai Country Attorney’s office. If not paid upon notification, the account(s) will be turned over to collections and charged a $25.00 service fee per account. Appointments for care will be suspended until account(s) is in good standing.

SERVICE CHARGE
Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.50 for a minimum balance of $25.00), equivalent to an annual percentage rate of 18% applied to the last month’s balance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. **Please be advised that there is a $40.00 fee charged for missed or broken reservations without 24 hours’ notice. To avoid this charge, kindly give us a minimum of 24 hours’ notice for any appointment cancellation.**
Feel free to contact us at any time with questions you may have.

Authorization
I have read and understand the above Payment Policy. I hereby authorize payment directly to Jason C. Campbell DDS PLLC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient’s dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grand the right to Jason C. Campbell DDS PLLC to release the patient’s dental and/or medical histories and other information about the patient’s dental treatment to third-party payers and/or other health professionals

_____ _____/_____/_____
SIGNATURE DATE

Pro Solutions Dental Group
FAMILY, IMPLANT, & RECONSTRUCTIVE DENTISTRY

INFORMATION REQUIRED FOR CASE HISTORY RECORDS
This complete confidential record is important for our records and your health.
THIS FORM MUST BE FULLY COMPLETED.

HIPAA RECORDS REQUEST FORM

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- 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 healthcare or with payment for your healthcare. 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.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for adults by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else

- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 11, 2016, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to use or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, call or visit our office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.D. 20201
(202)619-0257
TollFree:1-877-696-6775

Pro Solutions Dental Group
FAMILY, IMPLANT, & RECONSTRUCTIVE DENTISTRY

INFORMATION REQUIRED FOR CASE HISTORY RECORDS
This complete confidential record is important for our records and your health.
THIS FORM MUST BE FULLY COMPLETED.

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Pro Solutions Dental Group to use and/or disclose my protected health information to carry out the following:

Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.

Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.

The day-to-day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Patient Name (Printed)_____

SIGNATURE_____ **DATE** _____ **/** _____ **/** _____

If signing on behalf of someone, explain your relationship to the patient: _____

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.
The following circumstances prohibited the patient from signing the consent form: _____

_____

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

Office Personnel Signature: _____ Date: _____ / _____ / _____
Office Personnel Name: _____ Office Personnel Title: _____