



ELGIN FAMILY DENTAL

Carl F. Herring, D.D.S.

Scott B. Herring, D.D.S.

WELCOME

Patient Information (please print)

Patient Name	_____	Preferred Name	_____	Birthdate	_____	Age	_____	
	Last First MI							
Street Address	_____			City	State	Zip Code		
Billing Address	_____			City	State	Zip Code		
E-mail address	_____			SocSec#	_____	DL#	_____	
Home Phone	_____			Work Phone	_____		Cell #	_____
For confirmations, do you prefer to receive calls at your: <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Cell Best Time to Call _____								
Gender (M/F)	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Minor							
If Student, Name of School/College _____				City	State	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
Patient or Parent/Guardian's Employer	_____			Work Phone: _____				
Business Address	_____			City	State	Zip Code		
	Street							
Spouse or Parent/Guardian's Name	_____			Employer	_____		Work Phone	_____
<i>Person to contact in case of emergency: (Specify Someone Who Does Not Live With You)</i>								
Name	_____			Relationship	_____			
Home Phone	_____			Work Phone	_____			
Name of Person Responsible for this Account	_____			Relationship to Patient	_____			
Address	_____			Home phone	_____			
Email	_____			Cell phone	_____			
DL#	_____			Birthdate	_____			
Employer	_____			Work Phone	_____			
Is this Person Currently a Patient in our Office? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Whom may we thank for referring you? _____								

Primary Insurance

Name of Insured	_____			Relationship to patient	_____		
Birthdate	_____	SS#	_____	Date Employed	_____		
Name of Employer	_____			Work Phone #	_____		
Address of Employer _____							
Insurance Company	_____			Group #	_____	Policy/ID #	_____
Ins Co. Address _____							
How much is your Deductible? _____ How Much have you used? _____ Max. Annual Benefit _____							
DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, COMPLETE THE FOLLOWING:							
Name of Insured	_____			Relationship to patient	_____		
Birthdate	_____	SS#	_____	Date Employed	_____		
Name of Employer	_____			Work Phone #	_____		
Address of Employer _____							
Insurance Company	_____			Group #	_____	Policy/ID #	_____
Ins Co. Address _____							
How much is your Deductible? _____ How Much have you used? _____ Max. Annual Benefit _____							

I Certify that the information given is correct. I will notify you of any changes in information as listed above.

Signed (Patient, Parent or Guardian)

Date

ELGIN FAMILY DENTAL 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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect __01__/_01___/_2010___, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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 to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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. You may also request access by sending us a letter to the address at the end of this Notice. We may charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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: Deborah Herring

Telephone: 512-281-3321 Fax: 512-285-3447 E-mail: dherring@elginfamilydental.com

Address: PO Box 32 Elgin TX 78621

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ELGIN FAMILY DENTAL
**Acknowledgement of Receipt of HIPAA
Privacy Policies and Procedures**

I, _____, have
received and reviewed a copy of Elgin Family Dental's health information
privacy and security policies and procedures.

Print
Name _____

Signature _____

Date _____



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FINANCIAL POLICY

Thank you for choosing Elgin Family Dental for your dental needs. We are committed to providing state-of-the-art, comfortable and personalized dental care for you and your family. Please read the following financial policy and sign in the space provided. Please ask any questions you may have concerning this policy. We will furnish you a copy at your request.

Photo ID and Insurance Card (if applicable) will need to be copied by office staff.

- **New Patient Emergency Appointment Payments:** In order for patients to establish credit in our office, we request payment at the time of service for new patient emergency procedures. For your convenience we accept cash, personal checks, money orders and credit cards (Visa, Master Card, American Express and Discover).

- **Non-Insurance Patients:** Patients without insurance are expected to pay for all services rendered. For your convenience we accept cash, personal checks, money orders, and credit card payments at the time of service. Interest free dental loans or an extended payment plan are available through CareCredit. We will help you fill out the necessary applications. For information on these services, please ask our office staff.

For crowns, bridges, partials and dentures: a laboratory retainer fee of half of the charged fee is due on the day impressions are taken unless prior payment arrangements have been approved.

- **Insurance:** When your appointment is made, we will ask for your insurance information, so we may verify this with your insurance company. You will also need to bring your insurance card to your appointment. We do ask that you read your policy thoroughly so that you are fully aware of the benefits provided and the limitations imposed. Most insurances are accepted at Elgin Family Dental. Please contact your insurance company with any questions regarding your coverage.

Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract; however, as a courtesy to our patients, we will file and accept assignment of insurance benefits. Once we confirm your dental coverage, you will be asked to pay your deductible and patient portion at the time of service. Not all services are a covered benefit in all contracts. Some employers and insurance companies arbitrarily select certain services they will not cover.

You are responsible for the cost of your treatment and any insurance reimbursement problems. It is unusual for all of the charges to be paid by insurance but our business office staff will strive to help you obtain your maximum benefits by prompt and efficient processing of your claims. Anticipation of benefits expected are clearly estimates. The actual balance due after the insurance payment is the responsibility of those seeking treatment. We do have several methods of payment designed to help you and your family get the quality of care you deserve. Please feel free to ask our office staff about options for payment.

Assignment of Insurance Benefits: I hereby authorize payment directly to Elgin Family Dental for the dental service benefits otherwise payable to me. **PLEASE INITIAL** _____

I understand that if performed dental services are not under contract with my insurance carrier or I have met my contract limitations, I am responsible for this fee. **PLEASE INITIAL** _____

- **Children:** The parent or guardian who brings the child into the office for dental treatment is financially responsible regardless of dental insurance or legal responsibilities another parent or guardian may have toward this child.

- **Cancellations of Appointments/No show (did not call to cancel appointment):** When you do not show for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It's very important that you call with in 24 hours in advance to cancel your appointment. After 3 "no-shows", we will require you to pay a deposit for the appointment in advance before we can schedule you another appointment. We reserve the right to deny any future scheduling of appointments due to repeatedly missed or canceled appointments. **PLEASE INITIAL** _____

- **Past Due Accounts/Returned Checks:** An interest charge of one percent (1%) per month will be charged to your account after 90 days. Outstanding balances after 90 days will be transferred to a collection agency unless prior arrangements have been made with our front office. Patients, who have allowed their account to be turned over to collections, will be expected to satisfy their financial obligation to Elgin Family Dental and to pay future services in advance, before being seen by the dentist. I understand that any collection fees become my responsibility and will be added to my account, should it become necessary. There will be a \$30.00 fee for each returned check. In addition, you will be asked to bring cash to Elgin Family Dental to cover the returned check and the returned check fee. **PLEASE INITIAL** _____

I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS POLICY

Signature of patient or legal guardian if patient is a minor

Date