



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

Notice of Privacy Practices

Carl F. Herring, D.D.S. Inc., DBA Elgin Family Dental

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. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

How We May Use and Disclose Your Protected Health Information

When we give you our Notice of Privacy Practices, you will be asked to sign an Acknowledgment of Receipt. Once you have received our Notice and signed the Acknowledgement, we will use your protected health information for treatment, payment and healthcare operations. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgement of Receipt as soon as reasonably practicable after the delivery of treatment. The following examples show the types of uses and disclosures of your protected health information that our office is permitted to make.

Treatment: Your protected health information may be used and disclosed by our office and others outside of our office that are involved in your dental care. We will use and disclose your protected health information to other dentists and physicians who provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dental specialist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payment: Your protected health information may be used and disclosed to pay your health care bills. Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training and conducting auditing or review activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. We may also call your name in the waiting room when your doctor is ready to see you. We may send you reminder postcards or telephone you to remind you of an appointment. We may also send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities for our practice. Whenever we disclose your protected health information to a business associate, we will have a written contract that will protect the privacy of your protected health information.

Your Written Authorization Is Required For Other Uses of Your Protected Health Information

Any other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your health information as provided for in your authorization.

Use and Disclosure Permitted Without Authorization but With An Opportunity To Object

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your dental care or with payment for the services we have provided. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions or other similar forms of health information.

Other Disclosures That May Be Made Without Your Authorization

Required by Law: We may use or disclose your protected 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 that of other persons.

Military Personnel and National Security: We may disclose the health information of Armed Forces personnel when requested by command military authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities.

Worker's Compensation & Health Oversight Activities: We may disclose your protected health information to comply with worker's compensation Laws and to health oversight agencies when conducting investigations or inspections as authorized by law.

Required uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliance.

You Have the Following Rights

Inspect and copy your protected health information: 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 practically do so. You must make the request in writing to obtain access to your health information. You may obtain access by sending a letter to our Privacy Officer listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Request a restriction of your protected health information: 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.

Request alternative communications: 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 alternative locations and provide satisfactory explanation how payments will be handled under the alternative means or locations you request.

Request an amendment to your health information: You have the right to request that we amend or correct your health information. Your request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain situations.

Request an accounting of disclosures we have made of your health information: You have the right to an accounting of disclosures of your health information that occurred after April 14, 2003. This accounting will be for purposes other than treatment, payment or healthcare operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee.

If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

Questions and Complaints: If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Elgin Family Dental
Privacy Officer
306 North Hwy. 95, PO Box 32
Elgin, Texas 78621
(512) 285-3322 Metro: (512) 281-3321



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of
(Name of Patient, please print)

ELGIN FAMILY DENTAL'S Notice of Privacy Practices.

(Signature of Patient - Parent/Guardian if patient is a minor)

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

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Communications barriers prohibited obtaining the acknowledgement

_____ Other (Please Specify) _____

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