DRS. NEIGHBORS, HEROD and MORETTI

INFORMED CONSENT DURING COVID-19

COVID-19 is an infectious virus that currently has no direct treatment and for which there is no current vaccine. While we have taken reasonable steps to limit the potential for transmission of COVID-19 in our office, you agree that you understand transmission of COVID-19 is still possible.

By necessity, dentistry requires that our staff and health care providers be within 6 feet of you and will need to touch you and, potentially, your personal objects. You understand that person-to-person contact may increase the chance of COVID-19 transmission. It may be necessary that you quarantine and/or take other steps in the event it is determined that you may have been exposed to COVID-19.

You further understand that recommendations and guidelines regarding COVID-19 are subject to modification.

I have been given the opportunity to ask questions and all my questions have been answered.

I have read and understand the information stated above:

_____

Signature

_____

Name (please print)

_____

Date

DENTAL REGISTRATION

(PLEASE PRINT)

DRS. NEIGHBORS, MORETTI AND HEROD
1009 Crowder Drive
Midlothian, VA 23113
Telephone: (804) 794-8745

Date _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
LAST FIRST MIDDLE INITIAL

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

E-mail Address _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Reason for today's visit: _____

_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
LAST NAME FIRST NAME MIDDLE INITIAL

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Subscriber # _____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____

Subscriber # _____

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. If my account becomes delinquent, I agree to reimburse Drs. Neighbors, Moretti and Herod the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees incurred in such collection efforts.

_____ _____ _____
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

MEDICAL HEALTH HISTORY
(Confidential)

Patient Name _____ Birthdate _____
Last First Initial

MEDICAL HISTORY

Primary Care Physician _____

Physician's Phone Number _____ Date of Last Visit _____

Have you had any serious illnesses or operations?_____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have you ever had a joint replacement? ☐ Yes ☐ No If yes, give approximate dates _____

Have you taken any medications for osteoporosis? ☐ Yes ☐ No If yes, please list_____

_____

Do you smoke? ☐ Yes ☐ No Chew tobacco? ☐ Yes ☐ No If yes, how much daily_____

_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Cough up Blood	☐ HIV / AIDS	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Emphysema	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Organ Transplant	☐ Tonsillitis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease
☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever	
☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever	

MEDICATIONS

List medications you are currently taking. Please include over the counter medications and herbal supplements:

Medication _____

_____

_____

Pharmacy Name _____ Phone # _____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic	☐ Latex _____
☐ Barbiturates (Sleeping pills)	☐ Penicillin	☐ Other _____
☐ Codeine	☐ Sulfa	☐ Other _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

DRS. NEIGHBORS, HEROD and MORETTI

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Drs. Neighbors, Herod & Moretti

(804)794-8745 (ph)

www.midlodental.com

PATIENT HIPAA CONSENT FORM

Authorization to Disclose Protected Health or Billing information

I give permission to share my health and/or billing information with the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please read over and initial the following statements:

- I understand that anyone in the exam room will hear my private health information
  _____ **INITIALS**

- I give permission to the office of Drs. Neighbors, Herod & Moretti to leave a detailed message at the following phone numbers:

  _____

  _____

  _____ **INITIALS**

- I give permission to the office of Drs. Neighbors, Herod & Moretti to communicate with me electronically at the email address below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address and that I can withdraw my consent to electronic communications at any time by calling (804)794-8745.

  _____

  _____ **INITIALS**

  Patient Signature: _____ **Date:** _____

  Patient Representative (if patient unable to sigh or under 18):

  _____ **Date:** _____

  Description of Representative's Authority:

  _____

DRS. NEIGHBORS, HEROD and MORETTI
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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/12/2019 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. 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, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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 if 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.

Our Privacy Official: Susan Gillis

Telephone: 804-794-8745 Fax: 804-794-3568

Address: P. O. Box 158 – 1009 Crowder Drive Midlothian, VA 23113

E-mail: info@midlodental.com