DENTAL REGISTRATION

(PLEASE PRINT)

DRS. NEIGHBORS, HEROD & MORETTI

1009 Crowder Drive

Midlothian, VA 23113

(804)794-8745 (ph)

DATE _____

PATIENT INFORMATION

Name _____ SSN _____
LAST FIRST MIDDLE INITIAL

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

☐ Please check here to consent to having text messages sent to the cell phone number indicated here

Sex ☐ M ☐ F Age _____ Date of Birth _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

E-mail Address _____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone _____

Reason for today's visit: _____

_____

PRIMARY DENTAL INSURANCE/GUARANTOR INFORMATION

Person Responsible for Account _____
LAST NAME FIRST NAME MIDDLE INITIAL

Relation to Patient _____ Date of Birth _____ SSN _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Policyholder Employer _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Insurance Phone _____

Subscriber ID# _____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional dental insurance? ☐ Yes ☐ No

Policyholder's Name _____
Last Name First Name Middle Initial

Policyholder Employer _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Insurance Phone _____

Subscriber ID# _____

MEDICAL HEALTH HISTORY

Patient Name _____ **Date of Birth** _____

MEDICAL HISTORY

Primary Care Physician _____

Physician's Phone Number _____ Date of Last Visit _____

Have you had an serious illnesses or operations? ☐ No ☐ Yes—describe: _____

Have you ever had a blood transfusion? ☐ No ☐ Yes—approximate date(s): _____

Have you ever had a joint replacement? ☐ No ☐ Yes—approximate date(s): _____

Have you taken any medications for osteoporosis? ☐ No ☐ 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/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 any medications you are taking, please include over the counter medications and herbal supplements:
Medication(s):

_____

_____

_____

_____

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(s) 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 & Moretti

(804)794-8745 (ph)

www.midlodental.com

PATIENT HIPAA CONSENT FORM

Authorization to Disclose Protected Health or Billing information

PATIENT NAME: _____ **DOB:** _____

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/Guardian Signature: _____

Relationship (if other than patient): _____ **Date:** _____

DRS. NEIGHBORS, HEROD & MORETTI

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Copies of the Notice of Privacy Practices are available in the waiting room.

If you would like a copy for to retain for your records, please let the front desk know.

By signing below, I acknowledge that a copy of this office's Notice of Privacy Practices was made available for my review.

You may refuse to sign this acknowledgement

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

PATIENT NAME IF SIGNING FOR A MINOR: _____

RELATIONSHIP TO PATIENT: _____

----------**FOR OFFICE USE ONLY**----------

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

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

_____

_____

_____

_____

NEIGHBORS & HEROD
FAMILY DENTISTRY

FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to ensuring your treatment is successful and meets your satisfaction. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require be reviewed and signed by all patients, and/or guardians of.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services which can include insurance verification and pre-treatment estimates. These services are done at the request of the patient; however, we always encourage you to reach out to your plan directly for any questions regarding network status with our office and to inquire as to what benefits you have available under your specific plan. Some, or perhaps all, of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility regardless if your insurance company pays any portion. If you have any questions regarding the pre-treatment estimate and/or fees for service, it is your responsibility to resolve those prior to treatment in order to minimize any confusion on your behalf.

By signing below, you are acknowledging you understand you are financially responsible for all charges whether or not paid by insurance. If your account becomes delinquent, you agree to reimburse Drs. Neighbors, Herod and Moretti 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 attorney's fees incurred in such collection efforts.

Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (for minor patients): _____

Relationship to Patient: _____ Date: _____

NEIGHBORS & HEROD
FAMILY DENTISTRY

CANCELLATION AND BROKEN APPOINTMENT POLICY

A reserved appointment time in any dental office is limited and valuable. Your appointment time is reserved especially for you. If you do not come, not only is your own care delayed, but other patients are not able to be treated during that time. It is extremely important that all patients honor their reserved appointment time(s).

As a courtesy to staff and other patients, our office requires a 24-hour notice for appointment cancellations/reschedules. Appointments that are cancelled/rescheduled with less than 24-hours' notice may incur a $50 broken appointment fee. In some cases, especially for longer appointment times, you may be asked to give greater notice. There is generally no charge for the first missed appointment but in effort to discourage repetitive broken appointments we may assess a broken appointment fee for the second and each subsequent occurrence.

Occasionally we may ask you to reserve your appointment with a deposit toward your treatment. This allows us to exclusively reserve your appointment time. This deposit will be credited to the treatment cost, however if the appointment is cancelled/rescheduled with insufficient notice the deposit will be considered non-refundable.

Every effort is made to contact patients to confirm scheduled appointments. Please understand that this is a courtesy call, text and/or email. It is the patient's sole responsibility to honor a scheduled appointment. Inability to reach you does not serve as a notice of cancellation.

Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (for minor patients): _____

Relationship to Patient: _____ Date: _____

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 X103 Fax: 804-794-3568

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

E-mail: info@midlodental.com