Brush Dentistry New Patient Registration

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Personal Information

Patient Name _____
Last First Middle (Preferred)

Address _____ City _____ State _____ Zip _____

DOB _____ SS# _____ DL# _____ Gender: □ M □ F Married: □ Yes □ No

Work #_____ Cell # _____ Home # _____ Email _____

Preferred contact method: □ Cell Phone □ Work Phone □ Home Phone □ Email

Place of employment _____ Spouse Name _____

If dependent over age of 19: □ Full-time Student □ Part-time Student □ Not a Student

How did you hear about us? Please be specific so we can thank them. _____

_____

Responsible Party Information:

Guarantor Name _____
Last First Middle (Preferred)

Relationship: _____

Address _____ City _____ State _____ Zip _____

DOB _____ SS# _____ DL# _____ Gender: □ M □ F Married: □ Yes □ No

Work #_____ Cell # _____ Home # _____ Email _____

Primary Insurance

Patient relationship to subscriber: □ Self □ Spouse □ Child

Subscriber Name_____ DOB _____

Insurance Company _____ Phone Number _____

Employer _____ Subscriber ID/SS# _____ Group #_____

Electronic Communication

I agree that Brush Dentistry may communicate with me electronically at the email address above. 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. I can withdraw my consent to electronic communications by calling 682-231-2764.

Signature _____ Date _____

Dental History

Patient Name _____ DOB _____

Reason for today's visit _____

Former dentist _____ Reason for leaving last dentist _____

How long since your last dental visit? _____ How long since your last cleaning? _____

How often do you brush? _____ Floss? _____ Type of toothbrush _____

If you could change anything about your smile, what would you change? _____

Please mark "Yes" or "No" if you have, or have ever had, any of the following:

Bleeding Gums	□ Yes □ No	Jaw Pain/Fatigue	□ Yes □ No
Clicking/Popping Jaw	□ Yes □ No	Sensitivity to Sweets	□ Yes □ No
Jaw Locked Open/Closed	□ Yes □ No	Sensitivity to Biting	□ Yes □ No
Food Caught Between Teeth	□ Yes □ No	Sensitivity to Cold	□ Yes □ No
Grinding/Clenching	□ Yes □ No	Sensitivity to Hot	□ Yes □ No
Gum Treatment	□ Yes □ No	Sores/Growths in Mouth	□ Yes □ No
Gums Swollen/Tender	□ Yes □ No	Dry Mouth	□ Yes □ No

Medical History

Physician's Name _____ Phone # _____ How long since last visit? _____

Do you use tobacco? _____ Women: Are you pregnant? _____ Nursing? _____

Allergies: □ None □ Aspirin □ Penicillin □ Codeine □ Sulfa □ Latex □ Other _____

Please mark "Yes" or "No" if you have, or have ever had, any of the following

AIDS/HIV	□ Yes □ No	Cold Sores	□ Yes □ No	Psychiatric Care	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Diabetes	□ Yes □ No	Radiation Treatment	□ Yes □ No
Artificial Joint/Pins Screws	□ Yes □ No	Glaucoma	□ Yes □ No	Reflux/GERD	□ Yes □ No
Arthritis	□ Yes □ No	Heart Problems	□ Yes □ No	Require Premed	□ Yes □ No
Asthma	□ Yes □ No	Hepatitis	□ Yes □ No	Seizures	□ Yes □ No
Autism	□ Yes □ No	High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
Bleeding Disorder	□ Yes □ No	High Cholesterol	□ Yes □ No	Surgeries	□ Yes □ No
Breathing Problems	□ Yes □ No	Kidney Disease	□ Yes □ No	Thyroid Problems	□ Yes □ No
Cancer	□ Yes □ No	Liver Disease	□ Yes □ No	Tuberculosis	□ Yes □ No
Chemical Dependency	□ Yes □ No	Lupus	□ Yes □ No	Tumor/Growth	□ Yes □ No
Chemotherapy	□ Yes □ No	Nervous Problems	□ Yes □ No	Other:	
Circulatory Problems	□ Yes □ No	Pacemaker	□ Yes □ No		

Medications

Please list medications you are taking (prescription and over the counter)

Signature

The information I have provided on this form is complete, truthful and accurate. I understand that withholding pertinent information may prevent proper and/or optimal treatment.

Patient/Parent Signature_____ Date _____

Brush Dentistry Financial Policy

Insurance

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and downgraded benefits. You are responsible for the difference between the services received and the downgraded services. You are also responsible for denied services.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Payment

1) Self-pay patients are expected to pay for services in FULL at the time of the visit or set up a recurring payment plan agreement. Insured patients are expected to pay the estimated patient portion at the time of the visit in full or set up a recurring payment plan agreement. If the actual amount due is different from the estimate, you will be responsible for the difference.
2) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of the bill.
3) For scheduled appointments, prior balances must be paid prior to the visit.
4) We accept cash, checks, Visa, MasterCard, Discover and American Express credit and debit.

Fees

1) If you are not able to keep an appointment, we would appreciate 48 hours notice. **There is a charge of $25 for missed appointments or appointments cancelled/rescheduled with less than 48 hours notice.**
2) The estimated patient portion of the treatment fees are due at the time of service. A **5% processing fee** will be charged in addition to your estimated treatment fee if a recurring payment plan was selected to extend payment over four months.
3) Any balance outstanding longer than 90 days will be forwarded to a collection agency. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of **50% of the account balance**, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.
4) A **$50 fee** will be charged for any checks returned for insufficient funds.

Signature

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient's Name: _____

Responsible Party Member's Signature_____ Date _____

Brush Dentistry 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 9/23/13, 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: Jennifer M. Libling, DDS
Telephone: 682-231-2764 Fax: 817-423-7483
Address: 1100 N. Blue Mound Rd. Saginaw, TX 76131
E-mail: brushoffice@gmail.com

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of Brush Dentistry'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)

Brush Dentistry Whitening For Life Club

Welcome to the Whitening for Life Club! We want you to enjoy white and healthy teeth. We believe it is extremely important to maintain recommended hygiene appointments and receive necessary dental treatment to maintain a healthy and beautiful smile. In fact, patients who maintain regular hygiene appointments and receive recommended treatment spend less money on dental care (on average) than those who only see the dentist when they perceive a problem exists.

The Whitening for Life Club was developed as an amazing opportunity for those patients that are already taking their dental health seriously, and as an incentive for those who need a little help keeping up with their dental care. You will initially receive custom made take home whitening trays, whitening gel and instructions. At every scheduled cleaning appointment, in our office, you will receive an additional syringe of whitening gel for life.

Below is a brief description of the qualifiers for this program. Please read through them carefully before you enroll.

Activation Rules and Regulations

- Must be at least 18 years of age.
- Must complete a comprehensive exam, x-rays, and recommended cleaning.
- **Must complete minimum required dental care at Brush Dentistry as treatment planned by doctor.**
- Must comply with broken appointment policy. At least **48 hours notice** is required to cancel or reschedule an appointment.
- **Cleaning appointments must be completed within 4 weeks** of the recommended time frame..
- Must not have an outstanding balance.

Lifetime Maintenance Rules and Regulations

- Must complete minimum required dental care as treatment planned by doctor, unless referred to a specialist.
- Must maintain continued hygiene care in our office (as often as recommended by our Doctors and staff).
- Must comply with Brush Dentistry payment and appointment policies.
- Any lost or damaged whitening trays will be replaced at a cost of $100 to the patient.
- If you are dropped from the Whitening for Life Club for not following the rules, you may reactivate your membership for a fee of $50.
- A maximum of one whitening solution refill will be awarded at each cleaning appointment up to four times annually.

Disclaimer: Brush Dentistry, its doctors and staff have the right to refuse offer if deemed necessary based on patient health conditions, misuse, abuse or any other factor deemed necessary to void offer. Minimum gum and teeth health required to receive professional whitening. We reserve the right to discontinue your enrollment in the Whitening for Life Club at any time if deemed necessary and for any reason.

I, hereby certify that I agree to the terms and conditions outlined above. I also acknowledge receipt of Brush Dentistry's Broken Appointment policy. I understand that the Whitening For Life Club is a privilege only bestowed to individuals who meet and maintain all of the rules and regulations pertaining to said program.

☐ Yes, please enroll me ☐ Decline

Patient Signature _____ Date _____

Patient Name (please print) _____