BUEHNER FAMILY DENTAL CARE

## Acknowledgement of Receipt of Notice of Privacy Practices

**You may Refuse to Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practice.

Print Name: _____

Signature: _____

Date: _____

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For Office Use Only

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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)_____

_____

# ACQUAINTANCE FORM

It is important that we get to know about you including your dental and medical history. many things have a direct bearing on our dental health. We will review this questionnaire and discuss it with you in detail. the information you give us is strictly confidential and will not be released to anyone without your permission.

## PATIENT INFORMATION

Patient's Name_____Email address_____

Address_____

Telephone: Home_____Cell_____Social Security #_____Date of Birth_____

Employer Name_____Work Telephone_____

Marital Status_____If Married, Spouse's Name_____

## EMERGENCY INFORMATION

In Case of Emergency Contact_____ Relationship _____

Address_____Telephone_____

## INSURANCE INFORMATION

Dental Insurance Company Name _____

Address_____

Group #_____Subscriber Name_____Social Security #_____

IF DUAL COVERAGE--THE SECONDARY INSURANCE COMPANY:

Insurance Company Name_____Employer_____

Address_____Group #/Policy #_____

Relationship_____Subscriber Name_____Social Security #_____

## MEDICAL HISTORY

*Please check or circle any of the following which you **have** or **have had** and explain where necessary. List pharmaceuticals (**prescribed medications**) you are taking now for this problem.*

☐1 . AIDs_____

☐2. Anemias or Blood Discrasias_____

☐3. Arthritis, Rheumatoid or Osteo_____ _____

☐4. Asthma_____

☐5. Autoimmune Problems_____

☐6. Birth Control Pills, Hormone Replacement Therapy or Fertility Problems_____

☐7. Blood Clots or Stroke: Y/N Treatment: _____

☐8. Bone Problems, Osteoporosis
Treatment w/Bisphosphonates(Please circle or write): Fosamax Actonel Boniva Zometa oral or injection
Other:_____

☐9. Cancer or Tumors: Y/N Current Treatment:_____ Previous Treatment:_____

☐10. Depression or Nervous Disorders_____

☐11. Diabetes: Type I or Type II

☐A. Oral Medication_____ ☐B. Insulin Injections_____

☐12. Digestion Problems, Acid Relux, GERD_____

☐13. Epilepsy or Seizures: Y/N Last episode:_____

☐14.Hayfever or Allergies other than medications_____

☐15.Heart Problems_____

☐A. Cardiac Bypass Surgery_____ ☐B. Cardiac Pacemaker_____

☐C. Congenital Heart Defect_____ ☐D. Prosthetic Heart Valve_____

☐E. Heart Attack_____ ☐F. Heart Murmur, Mitral Valve Prolaspe_____

☐16. Hepatitis A,B, C or Liver Disease_____

☐17.High Blood Pressure_____ ☐18. Low Blood Pressure_____

☐19. Joint Replacement_____ Premedication: Y/N Antibiotic:_____

☐20. Kidney Problems_____

☐21. Lung Disease, COPD_____

☐22. Muscle diseases_____

☐23. Social Diseases_____

☐24. Thyroid Diseases_____

☐25. Tuberculosis or Symptoms of Tuberculosis_____

☐26. Other diseases not listed_____

**Please list any vitamins, supplements or herbal/homeopathic remedies that you are currently taking:**

_____ _____

_____ _____

_____ _____

**Are you allergic to any of the following:**

☐ Antibiotics ☐1.Penicillin ☐2.Erythromycin ☐3.Tetracycline ☐4.Sulfa ☐5.Keflex ☐6.Clindamycin ☐7.Other_____

☐Local Anesthetics like Lidocaine or Septocaine or Carbocaine ☐Epinephrine sensitivity_____

☐Aspirin ☐Codeine ☐Ibuprofen, Motrin, Advil ☐Aleve ☐ Narcotics_____

☐Latex ☐Metals of any kind_____

☐Other allergies to materials or medications_____

**Have you ever been advised to take medication (antibiotics or other medications) before a dental appointment? Y/N** (circle)
**If so, please explain**_____

Have you ever had a skin rash or a reaction to metal jewelry? Y/N (circle) To What?_____

Do you wear contact lens? Y/N (circle) Do you bleed excessively upon injury? Y/N (circle)

Do you drink alcohol? Y/N (circle) _____daily _____weekly _____monthly _____ socially_____

Do you smoke now or **have you ever** smoked? Y/N (if yes number of years) cigarettes/day_____

cigars_____ pipes_____ chewing tobacco or snuff_____

Women: Is there a possibility that you may be pregnant or trying to get pregnant? Y/N (circle)

If yes, how many months pregnant? _____

Have you ever had counseling for addictions to alcohol and/or prescription medications? Y/N (circle)

_____

Do you have reason to believe you are at risk for contacting infectious or sexually transmitted diseases?

Y/N (circle) If yes, please explain_____

Have you been a patient in the hospital in the past two years Y/N (circle) If so, please explain_____

_____

Date of last medical visit for a checkup or physical_____

Physicians name, address and phone number:_____

Are you experiencing emotional or physical stress or pressure in your work or at home? Y/N (circle)

Please explain_____

Is there anything other in your medical history that we have missed? _____

## DENTAL HISTORY

How long has it been since you were to see a dentist?_____

What service was rendered?_____ Were x-rays taken? Y/N (circle)_____

When was the last time a full series of x-rays was taken of your teeth?_____

Have you had regular cleanings and exams? Y/N (circle)

Do you have a fear or phobia or the dentist that prevents you from visiting the dentist on a regular basis? Y/N (circle)
Would you be interested in help to deal with this fear, such as the use of Nitrous Oxide? Y/N (circle)

Have you lost teeth? Y/N (circle) Why?_____

Have you had complications with extractions?_____

Have you worn braces?_____ When?_____ How Long?_____ Do you still wear retainers?_____

Have you had treatment for periodontal disease (gum disease) or where you told you had periodontal disease?_____ Please explain and give dates_____

How often do you brush your teeth? ____x/day AM___PM___ Do you floss?_____x/day

Do you use other hygiene aids?_____

Do your gums bleed when you brush?____ or floss?_____

Do you have an unpleasant taste in your mouth?_____

Are there any areas of your mouth where foods collects or wedges between your teeth?_____

Have you noticed a dry mouth? Y/N Excessive water drinking/sipping? Y/N Frequent Use of Lozengers? Y/N

Do you have clicking or popping sounds when you open or close your mouth?_____ Pain?_____

Do you clench or grind your teeth either during the day or at night?_____

Do you experience headaches?_____ Frequency? _____When do they come?_____

Are any of your teeth sensitive?_____ Sweets? _____Cold?_____ Hot?_____ Pressure?_____

## TREATMENT AUTHORIZATION

I consent to whatever dental procedures and anesthetics are necessary for treatment. I also understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature of Patient or Guardian_____Date_____

Signature of Dentist_____Date_____

BUEHNER FAMILY DENTAL CARE

# Co-Insurance and Deductible Policy

We would like to thank you for choosing us as your dental provider. We are committed to providing you with quality dental care. Buehner Family Dental Care has begun to participate with many more insurance companies which has allowed our office to provide an even wider range of services for many in the community. With the addition of these insurance companies our office policies must be modified as well. As part of a contract that the dental office signs with an insurance company we must collect co-insurance and deductibles at the time of service.

Effective January 1, 2017 Buehner Family Dental Care will begin to collect deductibles and co-insurance the day the dental services are provided. We ask the patients come prepared to pay any estimated cost associated with the visit at the time of the dental service provided.

If there is concern as to if one will be able to pay the deductible or co-insurance please speak to the front desk prior to being taken back for treatment. Payment arrangements will be discussed and can be agreed upon if at least a portion of the visit's co-payment or deductible is paid on the date of service.

We are aware this is a big change for our office and patients. Please be aware Buehner Family Dental Care will be understanding and do all it can to help with any issues that may arise due to the new policy.

I have read and understand this document as explained herein and agree to be bound by its terms. I understand that the office reserves the right to amend this policy at any time.

_____ _____

Signature of Patient or Responsible Party Date

# BUEHNER FAMILY DENTAL CARE

## Financial Policy

We would like to thank you for choosing us as your dental provider. We are committed to providing you with quality dental care and a clear understanding of our financial policy. Please understand that the payment of your bill is considered a part of your treatment. This is a breakdown of our policy which we require you read and sign prior to treatment. All patients must also complete a Patient Information/Health History and an Acknowledgement of Receipt of Notice of Privacy Practices before being seen by the doctor.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS COVERED BY PARTICIPATING INSURANCE CARRIER. WE WILL GLADLY ACCEPT MASTERCARD, VISA, DISCOVER, DEBIT CARDS, CASH OR PERSONAL CHECK. WE ALSO OFFER PAYMENT PLANS FOR TREATMENT AT OUR DISCRESSION.**

**Regarding Insurance**: **All charges you incur at each dental visit are your responsibility regardless of your insurance coverage.** We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. It is ultimately the patient's responsibility to know details of your dental benefits. It is also the patient's responsibility to verify if the practice is in or out of network with his or her insurance policy and to be aware of your maximum allowance. As a courtesy, it is our staff's only responsibility to assist patients in filing out and submitting the insurance claim. Patients with dental insurance will be responsible to pay the estimated insurance copayment of a procedural allowance and deductible at the beginning of treatment. As well as, authorize the assignment of the insurance benefits to us. After insurance benefits are received, if there is an overpayment, a refund will be sent to you. **If there is an additional amount due, we will send a statement balance. If it is a non participating insurance, any charges incurred in our office are your responsibility at time of service**; we will still file your insurance claim, and will mark the payment as payable to you directly. Your insurance claim can **ONLY** be submitted if we are supplied with the proper insurance information from you (i.e.: **insurance company address and phone number, subscriber's identification number and group number**). It is your responsibility to make sure your policy is active on your date of service. If your insurance company has not paid your claim within 45 days please contact your insurance company. Your dental plan may not cover certain procedures; however this does not mean these treatments are unnecessary. If you have questions regarding your dental plan, or a problem with a reimbursement level, contact your employer or insurance company. Our staff may be able to explain dental plan issues to you. But, it is your responsibility to be educated on the levels of coverage provided by your plan. **Patient's Initials: _____**

**Usual and Customary Rates**: Our practice is committed to providing good treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what is an appropriate charge.

**Missed appointments**: The first missed appointment will generate a letter outlining our policy.
The second missed appointment (within a 12 month period) will generate a charge of $35, plus a warning letter.
The third missed appointment (within a 12 month period) will generate a second charge of $50 and may cause dismissal from our practice.

**Returned Checks**: Patients will be charged $50 for each returned check, and are responsible for the amount owed.

**Accounts:** After 60 days from the date of service a 35% collection fee will be added to your account if there has been no attempt to make payment or set up a payment schedule. All accounts delinquent over 90 days and without a payment schedule will be turned over to a collection agency for further collection procedures. All past due accounts must be paid in full before you can schedule another appointment.

I have read and understand the financial policy as explained herein and agree to be bound by its terms. I understand that the office reserves the right to amend this policy at any time.

_____ _____

Signature of Patient or Responsible Party Date

# NOTICE OF PRIVACY PRACTICES

## Effective date of notice: April 14, 2003

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice contains important information about the privacy of your medical information. If you need this notice in another language or someone to interpret, please contact your local County Assistance Office. Language assistance will be provided free of charge.

Este aviso contiene información importante acerca de la privacidad de su información médica. Si necesita este aviso en otro idioma o alguien para que interprete, comuníquese con la Oficina de Asistencia de su Condado. La asistencia bilingüe será gratuita.

Данное уведомление содержит важные сведения относительно конфиденциальности вашей медицинской информации. Если вам нужно данное уведомление на другом языке или вам нужны услуги устного переводчика, обращайтесь в Бюро помощи вашего округа (County Assistance Office). Переводческие услуги предоставляются бесплатно.

此通知包括关于您的医疗信息的个人隐私方面的重要资料。如果您需要此通知译成其它语言或需要有人替你翻译，请联系您所在地区的郡县协助办事处。可提供免费语言协助.

**Thông báo này gồm những thông tin quan trọng về việc bảo mật các chi tiết y tế cá nhân của quí vị. Nếu cần có thông báo này bằng một ngôn ngữ khác hay người để thông dịch, xin quí vị liên lạc với Văn Phòng Trợ Cấp Địa Phương. Trợ giúp ngôn ngữ sẽ được cung cấp miễn phí.**

សំបុត្រនេះមានពត៌មានសំខាន់អំពីការរក្សាទុកជាសម្ងាត់នូវពត៌មានពេទ្យ
របស់ណែកអ្នក។ បើណែកអ្នកត្រូវការសំបុត្រនេះ ជាភាសាផ្សេងទៀត
ឬត្រូវការអ្នកណាម្នាក់ដើម្បីបកប្រែ
សូមទាក់ទងការិយាល័យដើលប្រើរបស់ណែកអ្នក។ ជំនួយខាង
ភាសានឹងផ្តល់ឲ្យដោយឥតគិតថ្លៃ។

The Department of Public Welfare (DPW) provides and pays for many types of health and social services. We also determine persons' eligibility to receive those services. When we do these things, we collect personal and health information about you and/or your family. The information we collect about you and/or your family is private. We call this information "protected health information."

DPW does not use or disclose protected health information unless permitted or required by law. DPW must follow new laws protecting the privacy of your protected health information. These new laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or disclosure to the minimum necessary to accomplish the intended purpose. This notice explains your right to privacy of your protected health information and how we may use and disclose that information. For more information on DPW privacy practices, or to receive another copy of this notice, please contact us. For information on how to contact us, see the "Questions or Complaints" section on page four of this notice.

We are required by law to follow the terms of this notice. We reserve the right to change this notice. If we make an important change in our privacy policies or procedures, we will provide you with a new privacy notice either by mail or in person.

### What Is Protected Health Information?

Protected health information is information about you that relates to a past, present or future physical or mental health condition, or treatment or payment for the treatment, that can be used to identify you. This information includes any information, whether verbal or recorded in any form, that is created or received by DPW or persons or organizations that contract with DPW. This includes electronic information and information in any other form or medium that could identify you, for example:

- Your Name (or names of your children)
- Address
- Date of Birth
- Admission/Discharge Date
- Diagnostic Code
- Telephone Number
- DPW Case Number
- Social Security Number
- Medical Procedure Code

## Who Sees and Shares My Health Information?

DPW professionals (such as caseworkers and other county assistance office and program staff) and people outside of DPW (such as employment and training contractors, health maintenance organization (HMO) staff, nurses, doctors, therapists, social workers and administrators) may see and use your health information to determine your eligibility for benefits, direct treatment or for other permitted reasons. Sharing your health information may relate to services and benefits you had before, receive now, or may receive later.

## Why is My Protected Health Information used and Disclosed by DPW?

There are different reasons why we may use or disclose your protected health information. The law says that we may use or disclose information without your consent or authorization for the reasons described below.

**For Treatment:** We may use or disclose information so that you can receive medical treatment or services. For example, we may disclose information your doctor, hospital or therapist needs to know to give you quality care and to coordinate your treatment with others helping with your care.

**For Payment:** We may use or disclose information to pay for your treatment and other services. For example, we may exchange information about you with your doctor, hospital, nursing home, or another government agency to pay the bills for your treatment and services.

**For Operating Our Programs:** We may use or disclose information in the course of our ordinary business as we manage our various programs. For example, we may use your health information to contact you to provide information about appointments, health-related information and benefits and services. We may also review information we receive from your doctor, hospital, nursing home and other health care providers to review how our programs are working or to review the need for and quality of health care services provided to you and/or your family.

**For Public Health Activities:** We report public health information to other government agencies concerning such things as contagious diseases, immunization information, and the tracking of some diseases such as cancer.

**For Law Enforcement Purposes and As Required by Legal Proceedings:** We will disclose information to the police or other law enforcement authorities as required by court order.

**For Government Programs:** We may disclose information to a provider, government agency or other organization that needs to know if you are enrolled in one of our programs or receiving benefits under other programs such as the Workers' Compensation Program.

**For National Security:** We may disclose information requested by the federal government when they are investigating something important to protect our country.

**For Public Health and Safety:** We may disclose information to prevent serious threats to health or safety of a person or the public.

**For Research:** We may disclose information for permitted research purposes and to develop reports. These reports do not identify specific people.

**For Coroners, Funeral Directors and Organ Donation:** We may disclose information to a coroner or medical examiner for identification purposes, cause of death determinations, organ donation and related reasons. We may also disclose information to funeral directors to carry out funeral-related duties.

**For Reasons Otherwise Required By Law:** DPW may use or disclose your protected health information to the extent that the use or disclosure is otherwise required by law. The use or disclosure is made in compliance with the law and is limited to the requirements of the law.

## Do Other Laws Also Protect Certain Health Information About Me?

DPW also follows other federal and state laws that provide additional privacy protections for the use and disclosure of information about you. For example, if we have HIV or substance abuse information, we may not release it without special, signed written permission that complies with the law. In some situations, the law also requires us to obtain written permission before we use or release medical or mental health/mental retardation and certain other information.

## Can I Ask DPW to Use or Disclose My Health Information?

Sometimes, you may need or want to have your protected health information sent to someone or somewhere outside of DPW for reasons other than treatment, payment or operating our programs. If so, you may be asked to sign an authorization form, allowing us to send your health care information somewhere other than for treatment or payment purposes, or for operating our programs.

The authorization form tells us what, where and to whom the information will be sent. You may cancel or limit the amount of information sent at any time by letting us know in writing.

If you are younger than 18 years old and, by law, you are able to consent for your own health care, then you will have control of that health information. You may ask to have your health information sent to any person who is helping you with your health care.

## What Are My Rights Regarding My Health Information?

As a DPW client, you have the following rights regarding your protected health information that we use and disclose:

**Right to See and Copy Your Health Information:** You have the right to see most of your protected health information and to receive a copy of it. If you want copies of information you have a right to see, you may be charged a small fee. However, you may not see or receive a copy of: (1) psychotherapy notes; or (2) information that may not be released to you under federal law.

If we deny your request for protected health information, we will provide you a written explanation for the denial and your rights regarding the denial.

DPW does not receive or keep a file of all of your protected health information. Doctors, hospitals, nursing homes and other health care providers (including an HMO, if you are enrolled in one) may also have your protected health information. You also have a right to your health information through your doctor or other provider who has these records.

**Right to Correct or Add Information:** If you think some of the protected health information we have is wrong, you may ask us in writing to correct or add new information. You may ask us to send the corrected or new information to others who have received your health information from us. In certain cases, we may deny your request to correct or add information. If we deny your request, we will provide you a written explanation of why we denied your request. We will also explain what you can do if you disagree with our decision.

**Right to Receive a List of Disclosures:** You have the right to receive a list of where your protected health information has been sent, unless it was sent for purposes relating to treatment, payment, operating our programs, or if the law says we are not required to add the disclosure to the list. For example, the law does not require us to add to the list any disclosures we may have made to you, to family or persons involved in your care, to others you have authorized us to disclose to, or for information disclosed before April 14, 2003.

**Right to Request Restrictions on Use and Disclosure:** You have the right to ask us to restrict the use and disclosure of your protected health information. We may not be able to agree to your request. In fact, in some situations, we are not permitted to restrict the use or disclosure of the information. If we cannot comply with your request, we will tell you why.

**Right to Request Confidential Communication:** You may ask us to communicate with you in a certain way or at a certain location. For example, you may ask us to contact you only by mail.

## Whom Do I Contact About My Rights or to Ask Questions About This Notice?

You can contact the DPW HIPAA helpline, toll-free at 800-692-7462 to discuss your rights or to ask questions about this notice. You can also contact your caseworker or health care provider or write to DPW's Privacy Officer, 3rd Floor West, Health and Welfare Building, 7th and Forster Streets, Harrisburg, PA 17120.

You can receive important information or updates to this notice by visiting DPW's Web site at www.dpw.state.pa.us.

## How Do I File a Complaint?

You may contact either office listed below if you want to file a complaint about how DPW has used or disclosed information about you. There is no penalty for filing a complaint. Your benefits will not be affected or changed if you file a complaint. DPW and its employees and contractors cannot and will not retaliate against you for filing a complaint.

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF PUBLIC WELFARE PRIVACY OFFICER
3RD FLOOR WEST, HEALTH AND WELFARE BUILDING
7TH AND FORSTER STREETS
HARRISBURG, PA 17120

REGION III
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS
150 S. INDEPENDENCE MALL WEST - SUITE 372
PHILADELPHIA, PA 19106-3499

PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
Improving the quality of life for all Pennsylvanians

www.dpw.state.pa.us

Edward G. Rendell
*Governor*

Estelle B. Richman
*Secretary*



PA 1806 7/06

BUEHNER FAMILY DENTAL CARE

# Sweet Tooth Discount Program

## For Adults and Children w/o Insurance

## In Office Discount Program Only

**$249 a calendar year for Adults**

**$189 a calendar year for Children**

**Benefits:**

- 2 Comprehensive Cleanings per year
- 2 Dental Exams per year
- 2 Periodontal Screenings
- 2 Oral cancer screenings per year
- 2 TMJ Evaluations
- All x-rays taken during those visits
- 10% off Future treatments/visits during the contracted year

**Please ask the staff for more information.**