LAKE COUNTRY DENTAL
RAY D. SNIDER, D.D.S., and ASSOCIATES
Cosmetic, Family and Implant Dentistry

WELCOME TO OUR PRACTICE

Patient Information

Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: HM (_____)_____ WK (_____) _____ CELL (_____) _____

Birthdate: _____ Social Security #: _____ Age: _____

Driver License #: _____ State: _____ Please circle: Male / Female Married / Single / Divorced / Widowed

Responsible Party Information

Name: _____ Social Security #: _____

Address: _____ City/State/Zip: _____

Phone: HM (_____) _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____ Age: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

How would you like to pay for today's visit? Credit Card / Check / Cash / Monthly Payments with approved credit

Insurance Information

Primary Insurance Co.: _____ Phone: (_____)_____

Employer: _____ Group #: _____ Employee Name: _____

Birthdate: _____ S.S.#: _____ Employee #: _____

Secondary Insurance Co.: _____ Phone: (_____)_____

Employer: _____ Group #: _____ Employee Name: _____

Birthdate: _____ S.S.#: _____ Employee #: _____

Getting To Know You

Are other members of your family patients at our office? YES / NO

Name(s): _____ Relationship: _____

Name(s): _____ Relationship: _____

How did your hear about our office? _____

Person to contact for emergency: _____ Phone: (_____) _____

Address: _____

Dental Health History (Confidential)

Reason for today's visit?: _____

Why did you leave your former dentist? _____ Date of last x-rays: _____

Do you have problems with any of the following:

____ Mouth Odor	____ Grinding Teeth	____ Heat Sensitivity
____ Bleeding Gums	____ Loose Teeth or Broken Fillings	____ Sweet Sensitivity
____ Clicking or Popping Jaw	____ Peridontal Disease/Treatment	____ Sensitivity to Biting Pressure
____ Food Collection Between Teeth	____ Cold Sensitivity	____ Sores or Growths in Mouth

How often do you floss? _____ How often do you brush? _____

Medical History (Confidential)

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? YES/NO If yes describe: _____

_____

Have you ever had a blood transfusion? YES/NO If yes give approximate date(s): _____

(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:

____ AIDS	____ Cortisone Treatments	____ Hepatitis Type _____	____ Rheumatic Fever
____ Anemia	____ Cough, Persistent	____ High Blood Pressure	____ Scarlet Fever
____ Arthritis, Rheumatism	____ Cough up Blood	____ HIV Positive	____ Shortness of Breath
____ Artificial Heart Valves	____ Diabetes	____ Jaw Pain	____ Skin Rash
____ Artificial Joints	____ Epilepsy	____ Kidney Disease	____ Stroke
____ Asthma	____ Fainting	____ Liver Disease	____ Swelling of Feet or Ankles
____ Back Problems	____ Glaucoma	____ Mitral Valve Prolapse	____ Thyroid Problems
____ Blood Disease	____ Headaches	____ Nervous Problems	____ Tobacco Habit
____ Cancer	____ Heart Murmur	____ Pacemaker	____ Tonsillitis
____ Chemical Dependency	____ Heart Problems _____	____ Psychiatric Care	____ Tuberculosis
____ Chemotherapy	_____	____ Radiation Treatment	____ Ulcer
____ Circulatory Problems	____ Hemophilia	____ Respiratory Disease	____ Venereal Disease

Do you need Antibiotic Premedication prior to dental treatment? YES / NO

List medications you are currently taking: _____

Allergies: ____ Aspirin ____ Penicillin ____ Codeine ____ Local Anesthetic Other: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information cab be dangerous to my health. I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include, but are not limited to bruising, hematoma; cardiac stimulation; temporary or rarely, permanent numbness; or muscle soreness. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event any dispute or claim arising from dental treatment or insurance claims cannot be settled by parties involves, all parties agree to submit said dispute to binding arbitration.

Date: _____ **Signature**: _____

Dr. Notes: _____

_____

Lake Country Dental

Ray D. Snider DDS & Associates

Pediatrics, Family Dentistry & Dental Implants

FINANCIAL POLICY

We appreciate you choosing Lake Country Dental for your family's dental care. At Lake Country Dental, we value our relationship with our patients and would like to offer the following as our payment policy:

If you have dental insurance, we will be happy to help you receive the maximum benefits available under your policy. However, please realize that the relationship is between you, the insured and your insurance company. If we do not receive payment from your insurance company within six weeks after submission of a claim, you will be expected to pay for all dental services in full. In the event of duplicate payments, your account will be reimbursed.

- A finance charge will be added to your account on any balance not paid by you or the insurance within six weeks from the date of service.
- Once the treatment plan and the estimated insurance benefits are reviewed with you, we require that you pay your portion in full at the time of service.
- For appointments that require the dentist to spend two or more hours with you during your appointment, a credit card will need to be provided to hold your appointment.
- For your convenience we accept cash, Visa, Master Card, Discover, American Express, and debit cards. We also offer Care Credit. Any Interest Free payment plans may include a financial planning fee.
- When impressions are taken for any restoration or appliance, the full fee is due when the appliance is ordered.
- Please note that the parent or guardian bringing the child into the office on the day of service will be expected to pay for services rendered. Only if payment arrangements have been made prior to appointment will we continue to see the child for treatment.

I have read and understand the payment policies for the office:

Patient's Name Printed: _____

Patient's Signature / Parent or Legal Guardian):

_____

Lake Country Dental
Ray D. Snider, DDS & Associates

Visitor Privacy Policy

This privacy policy is adopted to ensure that visitors to our Practice comply fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in termination of your visiting privilege and possible referral for criminal prosecution.

It is the policy of our Practice that visitors comply with our Notice of Privacy Practices. Copies of our Notice of Privacy Practices are available at our reception desk.

Responsibility

It is the policy of our Practice that the responsibility for designing and implementing procedures to implement this policy lies with the Privacy Officer.

Verification of Identity

It is the policy of our Practice that the identity of all persons who request access to Protected Health Information be verified before such access is granted.

Safeguards

It is the policy of our Practice that appropriate safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection of PHI. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this organization.

Business Associates

It is the policy of our Practice that business associates must comply with the HIPAA Privacy and Security Rules to the same extent as our Practice, and that they be contractually bound to protect health information to the same degree as set forth in this policy pursuant to a written business associate agreement. It is also the policy of our Practice that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate, or if that is not feasible, by notification of the HHS Secretary. Finally, it is the policy of our Practice that organizations that transmit PHI to our Practice or any of its business associates and require access on a routine basis to such PHI, including a Health Information Exchange Organization, a Regional Health Information Organization, or an E-prescribing Gateway, and Personal Health Record vendors, shall be business associates of our Practice.

Cooperation with Regulatory Agencies

It is the policy of our Practice that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy and security compliance reviews and investigations.

Investigation and Enforcement

It is the policy of our Practice that in addition to cooperation with Privacy Oversight Authorities, our Practice will follow procedures to ensure that investigations are supported internally and that members of our workforce will not be retaliated against for cooperation with any authority. It is our policy to attempt to resolve all investigations and avoid any penalty phase if possible.

Receipt and Acknowledgement

By signing below, you acknowledge as a visitor to our Practice that you have received, read and understand our Practice Privacy Policy.

_____

Signature

_____

Printed Name of Visitor

_____

Date

Lake Country Dental

Ray D. Snider DDS & Associates

Pediatrics, Family Dentistry & Dental Implants

No Show Policy

We understand schedules change and you may not be able to keep your appointment. If you are unable to keep your scheduled appointment, please call us 24 hours in advance. Failure to do so will result in a $35 cancellation fee per appointment. If you miss two appointments without proper notification we reserve the right to dismiss the patient from care.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

(DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

LAKE COUNTRY DENTAL & ASSOCIATES
8461 Boat Club Road
Fort Worth, TX 76179

I,_____, hereby acknowledge that I have received and/or reviewed a
(Print Patient Name)
copy of **Lake Country Dental & Associates'** *HIPAA Notice of Privacy Practices*.

I understand that **Lake Country Dental & Associates** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Lake Country Dental & Associates'** revised *HIPAA Notice of Privacy Practices* upon request. I understand that, if I have questions about **Lake Country Dental & Associates'** *HIPAA Notice of Privacy Practices*, I may contact:

Lake Country Dental & Associates
Ray D. Snider, DDS
8461 Boat Club Road
Fort Worth, TX 76179
817.236.8771

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Lake Country Dental & Associates** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Lake Country Dental & Associates'** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Ray D. Snider, DDS noted above, for assistance.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent/Guardian Print Name of Parent/Guardian

FOR OFFICE USE ONLY

Lake Country Dental & Associates made a good-faith effort to obtain Acknowledgement from the patient noted above, receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, **Lake Country Dental & Associates** was unable to obtain a signed Acknowledgement for the following reasons(s):

□ Refusal to sign Acknowledgement on _____ (date)

□ Communication barriers prohibited us from obtaining a signed Acknowledgement

□ An emergency situation prohibited us from obtaining a signed Acknowledgement

□ Other (describe): _____

Lake Country Dental
Ray D. Snider, DDS & Associates

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time