

PATIENT INFORMATION

Patient Last Name _____	First Name _____	M.I. _____
Street Address _____		P O Box/ Apt. # _____
City _____	State _____	Zip _____
Date of Birth ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Home # _____	Work # _____	Ext _____
Cell # _____		
Email Address: _____ (To be used for appointment notification only)		
Marital Status _____	Social Security # _____	Referring Dentist _____
F/T Student: <input type="checkbox"/> Yes <input type="checkbox"/> No Employer or School _____		
Spouse/Parent/Guardian _____	Work # _____	Cell # _____
Emergency Contact (not living with you) _____		Relationship _____
Home Phone _____	Cell Phone _____	Work _____

Payment

For your convenience, our office accepts Visa, MasterCard, Discover, American Express, Visa Check Card and local checks with valid GA I.D. **It is the policy of Marietta Endodontics to require payment in full, your estimated co-pay or balance forward at each appointment.** If you require an extended payment plan, we are pleased to offer **Care Credit**. You may choose from a variety of payment plans with no money down and 6 months interest free with a brief, confidential credit application made by phone or internet prior to your treatment.

Dental Insurance

Marietta Endodontics is **not** contracted with most insurance companies. Dental plans with **out-of-network benefits** are accepted at this office. Because insurance policies vary, we can only estimate your coverage due to complexities of insurance contracts. Dental insurance plans pay based on the premium paid by you or your employer. Higher premium plans pay more of the fees and have fewer exclusions. Some carriers pay according to a restrictive fee schedule and have exclusions based on prior conditions and length of time on the plan. Our fees generally, but not necessarily, fall within the *usual and customary* fee structure determined by your carrier. Not all dental services are covered by all dental plans.

Your estimated patient portion (co-pay) is due on the day of your dental services. Your estimated portion is based on information given to us by your insurance carrier. However, we may need to send you a statement when the estimate differs from the actual payment. We will bill your insurance company and allow them **60 days** to render payment. After 60 days, you are responsible for the entire balance.

Dental Insurance Information

Insurance Company _____	Customer Service Phone # _____
Claim Mailing Address _____	
Group # _____	Group Name (Employer) _____
Policy Holder's Name _____	Date of Birth ____/____/____
Member I.D. # or SSN _____	Member Address _____

I have read and acknowledge the financial & insurance policies stated above. Also, I have read and acknowledge the HIPAA Privacy Notice (provided on the back of this form). I understand that a copy of this privacy notice will be provided to me at my request.

Patient's Signature _____ **Date** ____/____/____

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (referred to as PHI in this notice) is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information:** Your protected health PHI may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
2. **Treatment:** We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to insure the physician has the necessary information to diagnose and treat you.
3. **Payment:** Your PHI will be used, as needed to obtain payment for your health care services. For example, your relevant PHI may be disclosed to your health/dental plan in an effort to obtain pretreatment authorization or payment for health care services.
4. **Health Care Operations:** We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employment review activities, training of dental students, licensing, conducting or arranging of business activities. For example, we may use or disclose your PHI, as necessary, to remind you of your appointment.

We may use or disclose you PHI in the following situations without your authorization. These situations include as required by law: **Public Health; Communicable Diseases, Health Oversight:** Abuse or Neglect; **Food & Drug Administration requirements; Legal Proceedings; Law Enforcement:** Coroners; Funeral Directors; Organ Donation; **Research:** Criminal Activity, Military Activity & National Security; **Workers Compensation; Inmates. Required Uses and Disclosures:** Under the law, we must take disclosures to you when required by Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW. You may revoke this authorization at any time in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS Following is a statement of your rights with request to your Protected Health Information.

- **You have the right to inspect and copy your PHI.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to the law that prohibits access to PHI.
- **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.
- **You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request,** even if you have agreed to accept this notice alternatively (i.e. electronically).
- **You may have the right to have your physician amend your PHI.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

We have the right to change the terms of this notice and inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice.

COMPLAINTS You may complain to us or to the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **APRIL 24, 2003**. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at our office phone number (770-422-3636).

A copy of this notice will be provided to you at your request.