HIPAA - SUMMARY OF PRIVACY NOTICE

Officer Name: Barb Cristea

Office Website: www.mikeasaydds.com

Office Phone Number: (512) 244-2796

Office Address: 16 Chisholm Trail Rd, Round Rock, TX

1. OUR LEGAL DUTY

Our practice is dedicated to maintaining the privacy of current and former patients' health and financial information as required by our internal policies and applicable law. We are also required by federal law to give you this notice explaining your rights, our legal duties and privacy practices. 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all PHI(Personal Health Information) that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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 contained in this Notice.

2. USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose PHI about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your PHI to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice. To Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section (Block 3) of this Notice. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to

the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI. Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization. Required by Law: We may use or disclose your PHI when we are required to do so by law. Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to the military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected PHI of inmate or patient under certain circumstances. Appointment reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voice-mails, e-mails, postcards, or letters).

3. PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected PHI, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected PHI must be made in writing. Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. You must submit your request in writing to the contact information provided at the bottom of this notice. Your first request within a 12-month period is free of charge, but our practice may charge you for additional request made within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the contact information provided at the bottom of this notice. Your request, in a clear and concise manner should describe; the information you wish restricted, whether you are requesting to limit our practice's use, disclosure or both or to whom you want the limits to apply.

Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are still entitled to receive this Notice in written form.

4. 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 you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI 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 PHI. 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.

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Chisholm Trail Dental Health

Registration

1. ABOUT YOU

Last Name | First Name | Middle Name or Initial

What you prefer to be called

Gender

○ Female ○ Male

Birthdate: mm/dd/yyyy | Age | Social Security Number: 333-22-4444

Mailing Address: | City

State | ZipCode | Home Phone (222) 333-4444

Work Phone: (555) 123-4567 | Cell Phone (555) 222-4444 | E-mail Address

Whom may we thank for referring you to our office?

Employer's Name/Company Name

Employer's Address

City | State | ZipCode

What is your Occupation?

Status:

○ Widowed ○ Separated ○ Divorced ○ Married ○ Single ○ Minor

Spouse's Name

Do you have children?

○ No ○ Yes

How many Children?

2. INSURANCE INFORMATION

Primary Dental Insurance Co. Name

Insurance Co. Address

City | State | ZipCode

Insurance Co. Phone # (555) 222-3333

Insured's ID#

Group #: (Plan, Local, or Policy #)

Insured's Name

Relation to Patient

Insured's Date of Birth mm/dd/yyyy

Insured's Employer

Secondary Dental Insurance Co. Name

Insurance Co. Address

City

State

ZipCode

Insurance Co. Phone # (555) 333-4444

Insured's ID#

Group #(Plan, Local, or Policy #)

Insured's Name

Insured's Relation to Patient

Insured's Date of Birth mm/dd/yyyy

Insured's Employer

3. ACCOUNT INFORMATION

Person ultimately responsible for account

What is your relation to patient

Billing Address

City

State

ZipCode

Social Security #(222-33-4444)

Driver's License #

Work Phone #(555) 333-4444

I hereby authorize assignment of my insurance rights and benefits to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Please click to acknowledge you agree with the above statement.

- ○ I do not Agree
- ○ Agree

What is your preferred payment method?

- ☐ Credit Card
- ☐ Check
- ☐ Cash

4. IN EVENT OF AN EMERGENCY

Whom should we contact?

Relation to Patient

Home Phone #(333) 222-4444

Work Phone #(222) 333-4444

Cell Phone #(222) 333-4444

Who is your Medical Doctor?

MD's Phone #(444) 222-5555

Page 2 - Dental Patient Medical History

5. DENTAL INFORMATION

Reason for today's visit:

○ Consultation ○ Emergency ○ Exam

Are you in pain?

○ Yes ○ No

How long in pain?

Please indicate by clicking on any of the following problems:

☐ Other ☐ Active Decay/Cavity(ies) ☐ Bad breath ☐ Ringing in Ears ☐ Red, swollen or bleeding gums
☐ Sensitive tooth, teeth or gums ☐ Locking Jaw ☐ Teeth grinding ☐ Blisters/Sores in or around the mouth
☐ Broken/Chipped tooth ☐ Stained teeth ☐ Lost/Broken Filling(s) ☐ Discomfort, clicking or popping in jaw

List other problems

Do you require pre-medication?

○ Don't know ○ No ○ Yes

Have you ever been treated for Gum Disease?

○ No ○ Yes

Previous Dentist (Name, and Address)

Phone #(222) 444-5555

Date of last Dental Exam:

Date of Last Dental X-rays:

Date of Last Dental Cleaning:

Have you had problems with previous dental treatment? If so, explain:

Times a day you brush?

Times a week you floss?

Rate your smile from 1-10

Type of tooth brush bristles?

○ Hard ○ Medium ○ Soft

Would you like whiter teeth?

○ No ○ Yes

Have you had orthodontic treatment?

○ No ○ Yes

Things you would change about your smile?

6. MEDICAL INFORMATION

What medications are you taking?

☐ Other(s) ☐ Vitamins/Supplements ☐ Meds for Osteoporosis ☐ Insulin ☐ Tranquilizers ☐ Blood Thinners
☐ Stimulants ☐ Muscle relaxers ☐ Pain killers (including aspirin) ☐ Nerve pills

Please list any Medications or Vitamins/Supplements you're taking

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax)

○ No ○ Yes

Phen-fen/Redux

○ No ○ Yes

Do you have or have you had any of the following diseases, medical conditions or procedures?

☐ Fibromyalgia ☐ Lupus ☐ ADD/ADHD ☐ Aspberger's Syndrome/Autism ☐ Organ Transplant
☐ Artificial Prosthetics ☐ Sleep Apnea ☐ Jaw Problems TMJ/TMD ☐ Respiratory Problems ☐ Eating Disorder
☐ Sinus Problems ☐ Nervousness ☐ Severe/Frequent Headaches ☐ Back or Neck Problems ☐ Drug Abuse
☐ Alcohol Abuse ☐ Rheumatic Fever ☐ Allergies ☐ Low Blood Presure ☐ High Blood Presure
☐ Hypoglycemia ☐ Diabetes ☐ Cold/Fever Blisters ☐ Tuberculosis TB ☐ Chest Pains ☐ Anemia
☐ Bleeding Problems ☐ Asthma ☐ Emphysema ☐ Dizziness/Fainting ☐ Scarlet Fever ☐ Leukemia
☐ Frequent Thirst/Urination ☐ Ulcers ☐ G.I. Problems ☐ Cosmetic Surgery ☐ Kidney Problems ☐ Gout
☐ Arthritis ☐ X-ray or Cobalt Treatment ☐ Mitral Valve Prolapse ☐ Venereal Disease ☐ Blood Disease
☐ Glaucoma ☐ Chemotherapy/Radiation ☐ Artificial Heart Valve(s) ☐ Seizures/Epilepsy ☐ Liver Problems
☐ Hepatitis ☐ Tumor(s)/Growth(s) ☐ Cancer ☐ Congenital Heart Defect ☐ Thyroid Problems ☐ Lung Disease
☐ Shingles ☐ Angina ☐ Heart Disease ☐ Pacemaker ☐ Heart Surgery ☐ Stroke ☐ Heart Attack
☐ Heart Murmur

Please list any other surgeries or medical conditions you have or ever had:

Are you allergic to any of the following?

☐ Sulfa ☐ Foods ☐ Dental Anesthetics ☐ Codeine ☐ Aspirin ☐ Tetracycline ☐ Amoxicillin ☐ Penicillin
☐ Latex

Please list any food you are allergic to.

Do you use tobacco?

○ Yes ○ No

If Yes, How used?

How long?

Rate general health from 1-10

Do you wear contact lenses?

○ No ○ Yes

For women: Are you taking Birth Control pills?

○ No ○ Yes

Are you taking hormonal replacement

○ No ○ Yes

Are you Pregnant?

○ Yes ○ No

If Yes, how long?

Are you nursing?

○ No ○ Yes

How many children have you had?

Please read and digitally sign.

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I acknowledge that by typing my full legal name below constitutes my digital signature.

☐ I acknowledge my digital signature below.

Print your Name to sign:

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