



2440 Fairburn Road, SW • Suite 301
Atlanta, GA 30331
404.349.7777
FAX 404.349.8459

Welcome to Our Practice

We are so pleased that you have selected our office for your dental care. Our goals will be to determine what dental treatment you need or want and to deliver it in the most efficient manner with clinical excellence and courtesy. We will teach you how to combine regular professional dental care with proper, daily oral hygiene to maintain optimum oral health for yourself and family.

Office hours are by appointment. Unless an unexpected dental emergency arises, we try to make sure that patients are seen at their scheduled appointment time. Please allow adequate travel time to our office and expect to be in our office for at least 2-3 hours. When appropriate, we prefer to schedule longer appointments and complete as much dental treatment at a time as we can. This allows maximum efficiency and as little disruption to your daily schedule as possible.

Our office offers simple financial arrangements. Your options include: Payment in-full, credit cards, electronic drafts and third party financing. Unless prior arrangements are made, payment in full is expected at the time treatment is provided. All patients with dental insurance pay \$50.00 on the first visit which goes toward the initial examination and diagnosis.

You can expect to receive the best dental care we can provide. Once you have explained your dental concerns and a thorough dental examination and necessary radiographs have been completed, a written treatment plan will be developed. Advantages and disadvantages of treatment, risks of treatment, options and costs of treatment will be presented. Any questions you have will be answered before treatment begins.

Following you will find several forms: medical / dental history, office policy, and HIPPA forms that you may complete before your first visit. Please bring them with you along with your insurance card or information as well as photo ID. Thank you for the opportunity to provide you with dental care.

Looking forward to treating you soon!
The Team at Family and Children's Dentistry



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Office Visits Are Available By Appointment Only

If your child has an emergency and needs to be seen, we ask that you call as early as possible for a same day appointment. This will help us to plan for all patients and lessen your waiting time in the office. Calling ahead to schedule appointments and limiting unexpected visits will greatly help us serve you better.

If you, your doctor, or hygienist should decide that additional time is needed to discuss a particular problem, a longer consultation appointment can *usually* be arranged at 8:00am, 12:00 noon, or 3:00pm.

Broken and Cancelled Appointments

Our office requires a two-day (48 hours) cancellation notice of confirmed consultations and appointments; otherwise, a missed appointment *charge* of \$50.00 will be added to your account.

Appointment Reservation Fees

An appointment reservation fee of \$50 is required for all treatment appointments with a fee under \$250.00. Treatment appointments over \$250.00 require a reservation fee of ¼ of the total service for the next appointment. In addition, cleaning appointments on Saturdays require a \$25 appointment reservation fee.

If any of the following occur:

- ◆ Cancellation with less than 48 hours notice
- ◆ No-show or missed appointment
- ◆ Late arrival requiring rescheduling
- ◆ Eating prior to a sedation appointment

the fee will be charged to your account. Otherwise, the fee will remain as a credit on your account and can be applied to future appointments.

Advance Appointments

If your daughter or son is coming home from college and will need a routine dental visit, please call six weeks ahead to reserve your appointment. Our appointments fill up quickly.

We schedule appointments up to six months ahead of time for your convenience. Please schedule your appointments as far in advance as possible.

Responsible Party

Date



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Payment Policy

We require all patients or guardians to show their insurance or managed care card and their photo ID. We will make copies for our permanent records. For minors, we will charge and hold responsible the parent or guardian that signs the treatment plan.

We cannot render services on the assumption that our charges will be paid by the insurance company. All services are charged directly to the patient / guardian, and he / she remains personally responsible for reports and itemizations to assist in making collections from insurance companies. The patient / guardian will credit any such collections to the patient's account.

Payment and Release of Information Authorization

I, _____, hereby authorize Family and Children's Dentistry to furnish information concerning my or my child's oral health care to the insurance company. I direct the insurer to pay, without evasion, directly to Family and Children's Dentistry, all benefits that result from this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay collection and / or attorney's fees associated with my failure to pay my debt. A photostatic copy of this authorization will be as valid as the original.

I hereby authorize Family and Children's Dentistry to release the medical information contained in my chart to my insurance carrier for the purpose of conducting chart reviews, as necessary.

Signature of Patient or Guardian _____

Date _____

Family and Children's 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 09/23/2013, 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:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;

o Notify a person who may have been exposed to a disease or condition; or

o 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: Jacquelyn Williams

Telephone: (404) 349 – 7777, Ext 106

Fax: (404) 349 - 8459

Address: 2440 Fairburn Road SW, Suite 301, Atlanta, Georgia 30331

E-mail: info@familyandchildrensdentistry.com

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“With a Lott of Love”

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ E-mail: _____
Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jacquelyn Williams
Telephone: (404) 349 - 7777 Ext 106 Fax: (404) 349 - 8459
E-mail: info@familyandchildrensdentistry.com
Address: 2440 Fairburn Road, Suite 301, Atlanta, Georgia 30331

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Family and Children's Dentistry

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office'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)

Agreement to Receive Electronic Communication Family and Children's Dentistry

Patient Name (First MI Last):

Date of Birth: _____

Parent/Guardian (First MI Last):

Relationship to Patient: _____

I agree that the Family and Children's Dentistry may communicate with me electronically at the email address below.

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: 404-349-7777

Email Address (PLEASE PRINT CLEARLY):

_____ @ _____

Patient/Parent Signature: _____

Date: _____

Authorization Form for Use or Disclosure of Patient Information

Family and Children's Dentistry

Patient Name (First MI Last):

Patient's Date of Birth: _____ Patient's Chart No.: _____

I hereby authorize Family and Children's Dentistry to use and disclosure the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

I _____ authorize the following people to accompany and discuss dental diagnoses (including x-rays, photographs, and other clinical information), treatment plans, treatment results, and statements of services for

_____.

I understand that some documents may have financial or demographic information included.

I understand that a parent or legal guardian must sign all treatment plans in order to consent to the treatment. Treatment will not proceed without a signature from a parent or legal guardian.

I understand that a parent or legal guardian must accompany the patient and remain on the premises for the duration of all sedation appointments.

The following person(s) may receive this patient information:

1. _____ Relationship to Patient _____
2. _____ Relationship to Patient _____
3. _____ Relationship to Patient _____
4. _____ Relationship to Patient _____
5. _____ Relationship to Patient _____

NOTE: PHOTO ID IS REQUIRED FOR EACH PERSON AT THE TIME OF THE VISIT.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official, Jacquelyn Williams, at 2440 Fairburn Road, SW, Atlanta, GA 30331. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the patient's 18th birthday or on the following date
(if no expiration date, write "None"): _____

Signature of Parent or Legal Guardian:

_____ Date _____

Print Name (First MI Last):

Relationship to Patient: _____

For office use only: Copy of signed authorization provided to the individual:

Date: _____

Initials: _____