

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

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. 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, 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 requesting it from us or print the online version.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. 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 will 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 as described in the "Notice of Privacy Practices."

Legal Guardian's Signature _____ Date _____



ASHEVILLE PEDIATRIC DENTISTRY FINANCIAL POLICY

Thank you for choosing our office to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these explanations of payment for services:

1. Payment:

- a. Payment is due in full by cash, personal check, or charge card at each appointment as services are rendered.
- b. We accept Master Card, Visa, and Discover.
- c. A charge of \$30.00 will be assessed on checks returned for any reason. After two incidents of returned checks, we will no longer accept checks.
- d. Any unpaid balance over 30 days will be subject to a finance charge of 18% APR.

2. Dental Insurance:

- a. Dental insurance is a contract between your employer and the insurance company. We cannot influence how much of our fees your insurance will cover. Your benefits are determined by the policy your employer purchased.
- b. As a courtesy, our office will file your child's dental insurance.
- c. Please be aware that the person bringing the child for dental care is legally responsible for payment of all charges.

3. Pretreatment Authorization:

- a. Some insurance companies request an estimate of the work to be done and the fees to be charged before determining their benefits to you (i.e., Impacted Canine Exposure).
- b. We will give you an estimate of necessary treatment and our fees which you may convey to your insurance company.
- c. It will be up to you to determine if you wish to proceed with treatment before the insurance benefit is determined.

4. Fillings:

- a. We offer white fillings (composite resins) and silver fillings (amalgams).
- b. Please understand that some insurance companies do not pay for a white filling (composite resin) at the same level as a silver filling (amalgam).
- c. In some cases, when the cavity is too large to be restored with a composite resin, the tooth will need to be crowned
 - i. We use silver-colored stainless steel crowns.
 - ii. If the tooth requires nerve treatment (pulpotomy or pulpectomy), the tooth will need to be crowned with a stainless steel crown.

5. Nitrous Oxide:

- a. Nitrous oxide is an inhalational sedation technique often used by pediatric dentists.
 - i. Nitrous oxide is a slightly sweet smelling inert gas that induces a sense of well-being and relaxation.
 - ii. It is very safe, perhaps the safest sedative agent in dentistry.
 - iii. It is non-addictive. It is mild, easily taken, and then quickly eliminated by the body.
 - iv. Your child remains fully conscious, keeps all natural reflexes, when breathing nitrous oxide/oxygen.
 - v. Nitrous oxide is not always covered by dental insurance.

6. Oral Sedation:

- a. Conscious sedation is a management technique that uses medications to assist the child to cope with fear and anxiety and cooperate with dental treatment
- b. Who should be sedated?



- i. Children who have a level of anxiety that prevents good coping skills or are very young and do not understand how to cope in a cooperative fashion for the delivery of dental care should be sedated.
- ii. Conscious sedation is often helpful for some children who have special needs.
- c. Oral sedation is not always covered by dental insurance. We thank you for the payment the day you schedule your child's oral sedation appointment.

7. Appliances:

- a. The cost of the appliance (space maintainer) is due the day the impression is taken. This is necessary because our office must pay for the lab fees when appliances are ordered, not when they are completed.
- b. Space maintainers are not always covered by dental insurance.

8. Emergency Treatment:

- a. All emergency treatment must be paid in full at the time the service is rendered.
- b. If an emergency occurs after normal business hours, an "After Hours Office Visit Fee" will be charged.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation is greatly appreciated!

I have read and understand my financial obligation to Asheville Pediatric Dentistry.

Legal Guardian's Signature _____ Date: _____



ASHEVILLE PEDIATRIC DENTISTRY APPOINTMENT INFORMATION

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call our office **at least 24 hours** in advance so that we may give that time to another patient.

- One parent is welcome back for their child's dental visit. The exception is during conscious sedation appointments, where we ask that the parent waits in the reception area.
- *All restorative (fillings, extractions, etc.) procedures for young children are scheduled in the morning.* Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.
- *If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.*
- Broken or missed appointments affect many people. If a broken/missed appointment occurs or a cancellation without 24-hours notice, our office reserves the right to NOT schedule any subsequent appointments and/or charge a broken appointment fee.
- *A parent or legal guardian (with official documentation) must be present during all appointments that the child patient is in the office.*

I have read and understand the appointment information.

Legal Guardian's Signature _____ Date: _____



Effective date of notice: 10/25/07
NOTICE OF PRIVACY PRACTICES
Asheville Pediatric Dentistry
Jennifer C. Jackson, DMD, MPH
76 Peachtree Road, Suite 100
Asheville, NC 28803-3131

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;



- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it



along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

I acknowledge that I was offered a copy of Dr. Jenny Jackson's Notice of Privacy Practices.

Signature of Parent/Guardian:



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: Asheville Pediatric Dentistry

Address: 76 Peachtree Rd, Suite 100

City: Asheville State: NC Zip Code: 28803

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Legal Guardian's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

