



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

“With a Lott of Love”



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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 5:00pm.

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.

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information 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 listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information 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 health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information 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 health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information 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 health information 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 health information, 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 health information based on a determination using our professional judgment disclosing only health information 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 health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information 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 health information 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 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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: *You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you for each page and per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)*

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must 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 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Pamela Almond

Address: 2440 Fairburn Road, Ste 301, Atlanta, Georgia 30331

Telephone: (404) 349 – 7777

Fax: (404) 349 – 8459

E-mail: fdentistry@earthlink.net

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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Family and Children's Dentistry

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: Pamela Almond

Telephone: (404) 349 - 7777 Ext 105

Fax: (404) 349 - 8459

E-mail: fcdentistry@earthlink.net

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please 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)

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Consent Form

THIS EXCLUDES SEDATION APPOINTMENTS!

I _____ authorize the following people to accompany and discuss dental treatment for

_____.

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

Signature _____ Date _____

Relationship to Patient _____

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