

# Milton Star, DDS & Associates

## NOTICE OF PRIVACY PRACTICES

**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.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these

purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

**For more information about our Privacy Practices, please contact:**

**Regional Manager**

Dwain Shearer  
7650 Belair Rd.  
Baltimore, MD 21236  
Ph #: 410-668-9070

**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
877-696-6775 (toll-free)

**PATIENT NAME** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_  
Last First Initial

**DENTAL HISTORY**

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-Rays \_\_\_\_\_

Address \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

Are you satisfied with your smile?  Yes  No If not, do you want to improve it?  Yes  No

Check (✓) if you have had problems with the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity to hot        | <input type="checkbox"/> Reaction to local Anesthetic |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets     |   |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal Treatment          | <input type="checkbox"/> Sensitivity when biting   |   |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in mouth |   |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had any of the following:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Respiratory Disease  |
| <input type="checkbox"/> Arthritis, Rheumatism  | <input type="checkbox"/> Cortisone Treatments    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of breath  |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Skin Rash            |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Jaw Pain            | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Swelling Feet/Ankles |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Tobacco Habit        |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer                |
| <input type="checkbox"/> Circulatory Problems   | <input type="checkbox"/> Hemophilia              |  |   |
| <input type="checkbox"/> OTHER _____            |  |  |   |

**MEDICATIONS**

List medications you are currently taking:  
\_\_\_\_\_  
\_\_\_\_\_  
Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**ALLERGIES**

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Penicillin  |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Sulfa       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Latex       |
| <input type="checkbox"/> Local Anesthetic              | <input type="checkbox"/> Other _____ |

**SIGNATURE**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

PLEASE PRINT NAME of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_

**DENTAL HEALTH HISTORY**

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_ MARRIED SINGLE MINOR MALE FEMALE  
LAST FIRST M

SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT.# CITY STATE ZIPBIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER**INSURANCE INFORMATION**MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION  
ADULTS – COMPLETE PRIMARY INSURED  
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED**PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY**

LAST	FIRST	M	
STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)	RELATIONSHIP TO PATIENT		
EMPLOYER	DENTAL INS. CO		
SS#	SUBSCRIBER #	GROUP #	

Has any member of your family ever been treated in our office ? Yes No

Whom may we thank for referring you to our office ? \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT.# CITY STATE ZIP**METHOD OF PAYMENT**Responsible party currently has an account with this office  
Yes No  
Payment in full at each appointment (cash or personal check)  
Payment in full at each appointment (VISA MC OTHER)  
Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_  
I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**

If I do not pay the entire new balance within \_\_\_\_\_ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of \_\_\_\_\_% per month (or a minimum charge of \$\_\_\_\_\_ for a balance under \$\_\_\_\_\_ ) which is an annual percentage rate of \_\_\_\_\_% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

**AUTHORIZATION**

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

**X** \_\_\_\_\_  
Patient or Responsible Party

Date \_\_\_\_\_ State Driver's License # \_\_\_\_\_

## **Patient Consent to receive Mail and/or Telephone Messages**

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*Please Print* (Last Name)

(First Name)

(M.I.)

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Email Address

### **Do we have your permission to:**

Send a recall appointment reminder to your home?      Y\_\_\_\_ N\_\_\_\_

Leave appointment, billing or dental information on  
your answering machine/voice mail/e-mail:      Y\_\_\_\_ N\_\_\_\_

I give permission to share appointment, billing or dental information with the person named  
below:

Name: \_\_\_\_\_

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Signature of Patient / Parent or Legal Guardian

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Date

### **Acknowledgment of Receipt of Notice of Privacy Practices**

I have received a copy of the Notice of Privacy Practices with an effective date of April 14,  
2003.

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Signature of Patient / Parent or Legal Guardian

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Date

# Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section and sign/date the bottom of this form.

\_\_\_\_\_ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

\_\_\_\_\_ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

\_\_\_\_\_ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

\_\_\_\_\_ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

\_\_\_\_\_ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

\_\_\_\_\_ There will be a fee of \$30.00 for any checks returned as Non-Sufficient Funds (NSF)

\_\_\_\_\_ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

***Interest charges of 1.5% per month or 18% APR***

***Collections fees (up to 42% of the full balance)***

***Legal fees for collection services***

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witnessed By