



Welcome to our office. We sincerely appreciate you choosing our office for your dental care needs. Please be assured that we will work hard to continually earn the trust you have placed in us. In order for us to serve you better, please take several minutes to complete this information as thoroughly as possible.

PATIENT INFORMATION

Name _____ Preferred Name _____ Sex M F
 Date of Birth ___/___/___ Social Security Number _____ - _____ - _____
 Address _____ City/State _____ Zip Code _____
 Home Phone _____ Cell Phone _____
 E-Mail Address _____
 What is the **best** way to confirm your appointments? Phone Calls Text Email (Please circle)
 Who may we thank for referring you to us for care? _____

EMPLOYER INFORMATION

Employer Name _____ Work Number _____
 Employer Address _____ City/State _____ Zip Code _____

INSURANCE INFORMATION (Please bring all ID cards to your first appointment so we can make copies.)

Dental Insurance

Employed By/Retired From _____
 Name of Insurance Co _____ Plan Name/Number _____
 Name of Insured Person _____ Group Number _____
 Social Security # of Insured _____ Insured Date of Birth ___/___/___

Medical Insurance

Employed By/Retired From _____
 Name of Insurance Co _____ Plan Name/Number _____
 Name of Insured Person _____ Group Number _____
 Social Security # of Insured _____ Insured Date of Birth ___/___/___

Supplemental Insurance

Employed By/Retired From _____
 Name of Insurance Co _____ Plan Name/Number _____
 Name of Insured Person _____ Group Number _____
 Social Security # of Insured _____ Insured Date of Birth ___/___/___

EMERGENCY CONTACT INFORMATION

Name _____
 Relationship _____
 Phone _____

PREFERRED PHARMACY

Name _____
 Address _____
 Phone _____

FINANCIAL GUIDELINE AGREEMENT

Thank you for choosing The Village Dental Center for your dental care. We are committed to the success of your dental health. To make our relationship more comfortable it is important to provide you with our financial guidelines. To avoid any misunderstandings, please feel free to contact us with any questions.

Please read and sign this agreement prior to your appointment

Our policy requires payment at the time of service for your visit. If you have Delta Dental, we will estimate your financial responsibility for the services you receive, and those fees will be expected at the time of service.

As a courtesy to all our patients, we will submit all necessary paperwork, narratives and x-rays when applicable to help expedite the processing of your claims in order for you to get the reimbursement you deserve. All insurance payments will be sent to you directly with the exception of those with Delta Dental insurance coverage. We do not accept assignment of benefits from any insurance company other than Delta Dental.(Premier)

TREATMENT ESTIMATES

We strive to give you an accurate estimate of the total investment for the recommended treatment. Occasionally additional treatment may be recommended based on a change in your dental condition or on other unforeseen factors. If additional treatment is necessary, we will inform you at the time it becomes apparent so that you can make an appropriate decision. Payment for additional services rendered will be due at the time of treatment.

PAYMENT OPTIONS

For your convenience, we accept cash, checks, Visa, Discover, MasterCard and American Express. We also have Care Credit financing available with both interest free, and extended payment plans.

APPOINTMENT CHANGES

We ask that you give us 24-hour notice in the event you need to change your appointment. This gives us the opportunity to offer your appointment time to another patient in need (dental emergencies). We appreciate this courtesy because the emergency patient waiting to schedule could be you in the future.

Signature _____ Date _____

"An Investment In Your Smile Pays Dividends For A Lifetime"



NOTICE OF PRIVACY PRACTICES

This notice takes effect September 2013 and will remain in effect until we replace it. It describes how health information about you may be used and disclosed by our practice and how you can obtain 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. Our privacy practices are developed to meet requirements as specified by law. If the law changes we will amend our privacy practices to reflect the changes in the law. We must follow the privacy practices that are described in this Notice while it is in effect. 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 laws, 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, inform you of changes in the Notice by getting a new signed copy from you, and we will provide copies of the new Notice upon request. 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, or to a care provider that is overseeing other health needs you may have.

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, or we could require a 3rd party to aid in collection of unpaid balances that are due.

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 will 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 as required by law, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or 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 personal health information 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 personal health information 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 personal health information 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 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 personal health information 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 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 personal health information 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. It should however be noted that we typically do not participate in research projects and this release is unlikely.

Coroners, Medical Examiners, and Funeral Directors. We may release your personal health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We their duties.

Fundraising. By law, 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 fundraising communications. Our office policy is to NOT fundraise with patient information.

Other Uses and Disclosures of Personal Health Information. If a situation arises that is not covered in the prior sections, we will seek your permission for health information disclosure, unless dictated to do so by law. Your privacy is important to us and we work hard to secure all patient health information to protect individual privacy.

YOUR HEALTH CARE 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 still have the right to receive a printed, or if possible, 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 any 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 person health information 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 on file.

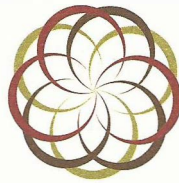
Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we decided 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 has 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 strict 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 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.

Privacy Contact: Amy Chrisman
13802 W. Camino Del Sol
Sun City West, AZ 85375



The Village Dental Center
Mathew J. Harmon, DMD

Acknowledgment of Receipt of the Village Dental Center's Notice of Privacy Practices

My signature below indicates that I have been given the opportunity to review a current copy of The Village Dental Center's "Notice of Privacy Practices". I also understand that an appointed person is available to answer any questions that I may have now or in the future regarding the use of my personal information.

Initial

Permission to take Photographs, Slides and Videos

I do authorize Dr. Matthew Harmon to take photos, slides, and/or videos of my face, jaws, and the hard tissues of my mouth. I understand that these will be the property of The Village Dental Center and may be published in dental journals, office manuals, and/or shown for educational purposes.

Initial

Print Name

Patient Signature

Date