Ridgeway Dental

3290 Ridgeway Dr. Suite 4 Coralville, IA 52241 319-626-2119

Patient Information

Patient Name: _____ Date: _____
Last, First MI (**Preferred Name**)

Birth Date: _____ Gender: _____ Family Status: _____

Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Preferred method for appt. reminders: Email:_____Phone call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the f ollowing? Please check those that apply:

- ☐ AIDS
- ☐ Allergies (please list)
  - Latex _____
  - Medication_____
  - Other _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Premed. _____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- Do you have problems sleeping/snoring? ☐ Yes ☐ No
- Have you ever used or are currently using nicotine products? ☐ Yes ☐ No
  If yes, are you interested in quitting? _____
- Have you ever used or are currently using recreational drugs? ☐ Yes ☐ No
  If yes, please list: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Have you ever been treated for periodontal disease? ☐ Yes ☐ No
  If yes, please list the name of the treating doctor _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Name of Insurance Company _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Referral Information

Whom may we thank for referring you to our practice? _____

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Ridgeway Dental Financial Agreement

It is our goal for patients to clearly understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatment affordable to all of our patients. We therefore offer the following financial arrangements:

1. **20% Cash Discount:** For cash and/or check payments in full at time of treatment.
2. **VISA – Mastercard – Discover – AMEX – Care Credit**
3. **Patients with Insurance:** Estimated portion not covered by insurance **due at time of treatment**.
4. **Patients without Insurance:** A completed payment plan and/or payment for dental services are due at the time of treatment.
5. **Care Credit Card:** Your estimated portion for treatment can be put on a CareCredit Account, our in-office financing partner. Applications for CareCredit are available at our front office or you can request approval online at www.carecredit.com.

For Our Patients with Dental Insurance

We are glad to assist you in obtaining maximum benefits from your dental insurance plan. To help us assist you, please bring your insurance benefit book and your insurance card to your first visit. Once your plan coverage is verified, we accept payment from your insurance company for the portion covered by your policy. Most plans cover only a part of the dental fee which means you are responsible for what your plan does not cover and any deductible. Many plans have exclusions and limitations which will affect your out-of-pocket expense. Please understand that our responsibility is to provide you with treatment that **best meets your needs**, not to try to match your care to insurance plan limitations.

Our staff will assist you in obtaining maximum dental insurance benefits, and will verify the coverage that your particular program provides. On the date of your office visit, **you are responsible for your deductible and the portion we estimate your insurance does not cover.** If your dental insurance company payment is not received within 75 days after the date of service, the entire balance is due from you. You can then obtain reimbursement directly from your insurance company.

In spite of what your plan says, we've found that many plans actually pay less than you might expect. The benefits your plan pays are largely determined by how much your employer/union pays in premiums for the plan. The less they pay for the plan, the less you'll receive. We are happy to submit your claims and help you receive the benefits due to you, but please understand that we cannot accept responsibility for collecting your insurance claim, or for negotiating disputed claims.

For treatment that requires dental laboratory services, a minimum down payment will be required at the initial appointment. A finance charge of 1.5% per month is applied on all account balances after 30 days.

Regardless of insurance coverage, you are responsible for payment of all dental fees for yourself and/or your dependents.

Please read the information above and let us know if you have any questions regarding the Financial Agreement. If you agree and understand this information please sign the Financial Agreement at your first visit.

Signature _____ Date _____

Ridgeway Dental Insurance Information/Policy

We accept most dental insurance plans. The amount of money each insurance plan will pay entirely depends on the specific dental plan, your coverage and the dental procedure. Please contact your insurance company with any specific questions you might have.

We are contract providers with Assurant, Blue Dental including BC/BS Fed., CIGNA Dental, Connection Dental, Delta Dental Premier, GEHA, Guardian, Humana, METLIFE and United Concordia. If you do not see your plan on this list, please give us a call as many insurances are under the Connection Dental umbrella.

We want our patients to be fully informed about the strengths and weaknesses of their dental plans when making decisions for dental treatment. Processing dental insurance has become much more complex in the last few years. To enable us to estimate your benefits, we ask that you provide us with as much information about your insurance plan as possible. Insurance fee schedules or benefit booklets are an invaluable tool in assisting our office staff. Please make yourself aware of your plan's exclusions and limitations, yearly maximum, deductible, and any possible waiting period.

There are often many factors involved in determining benefits for an individual when one insurance company is involved, and even more concerns when a coordination of benefits between two insurance companies is involved. In many instances a husband and wife may each have insurance coverage. It is a common fallacy however, that having two insurances guarantees 100% coverage. In fact, two dental insurance plans seldom means 100% coverage.

As a courtesy, we are pleased to estimate your benefits and bill your treatment to your insurance company. Our staff will assist you in obtaining maximum dental insurance benefits, but please understand that we deal with literally hundreds of different insurance plans every day. Although we try very hard to be as accurate as possible with our estimates, due to the sheer number of plans and their diverse benefits, we must rely on you, the subscriber, to assist us with information gathering.

Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if you feel that this applies to you.

It is also important that the office be notified when family circumstances change, especially if children are involved. Insurance companies have specific rules regarding which parent or stepparent is the primary insurance provider for a child.

Our office staff does its best to verify the coverage that your particular program provides. We accept payment from your insurance carrier for the portion covered by your policy. **On the date of your office visit, you are responsible for your deductible and the portion we estimate your insurance does not cover**. If your insurance company payment is not received within 75 days after the date of service, the entire balance is due from you. You can then obtain reimbursement directly from your insurance company.

If your insurance plan changes, or its billing address changes, it is your responsibility to inform us prior to any further claims being sent. We cannot be responsible for tracking changes in your plan. We appreciate your help, and look forward to working with you.

Signature _____ Date _____

Ridgeway Dental Appointment Policy

We want our patients to know how much we appreciate having you as part of our dental family. In an effort to provide the highest quality dentistry at affordable prices, we request 48 hours notice for any schedule changes that you may need in the future. Our office understands that sometimes emergency situations arise and we will handle each circumstance on an individual basis. We would like for our patients to understand that missed or broken appointments are hurtful in many ways. First and foremost, they delay your treatment and our ability to keep your oral health at optimum levels. Missed appointments may also prevent another patient, who is in need of treatment, from getting necessary care in a timely manner. In order for us to provide you with high quality dentistry at affordable prices, we must reduce the amount of missed appointments and no-shows. With this in mind, we want you to be informed of our appointment policy so there are no misunderstandings in the future.

We require 48 hours notice for all cancellations or changes in the schedule. Each patient may miss one appointment, due to an emergency without 48 hours notice in an 18 month period. If a second broken appointment occurs, you will be charged a $50 missed appointment fee. A third missed appointment will result in your dismissal from our practice. We will be happy to forward your records to a dentist whose hours better fit your schedule.

Thank you for your cooperation. We remain committed to your oral health.

Name (please print) : _____

Signature of patient or legal guardian: _____ Date: _____

RIDGEWAY DENTAL OFFICE PC

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:

- 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 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: Shannon O'Neill

Telephone: (319) 626-2119 Fax: (319) 626-2315

Address: 3290 Ridgeway Drive Suite #4 Coralville, IA 52241

E-mail: ridgewaydental@gmail.com

RIDGEWAY DENTAL OFFICE PC
Acknowledgment of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

Patient Name (Print):_____

Signature:_____

Date:_____

I authorize Ridgeway Dental to discuss all dental treatment and health information with the person(s) listed below.

Name:_____ Name:_____

Relationship with Patient:_____ Relationship with Patient:_____

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)

RIDGEWAY DENTAL OFFICE PC
Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address and/or cell phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails or text messages.

I am responsible for providing the dental practice any updates to my email address and cell phone number.

I can withdraw my consent to electronic communications by calling: **(319) 626-2119**

Email Address (PLEASE PRINT CLEARLY): Cell Phone Number (PLEASE PRINT CLEARLY):

_____@_____ _____

Patient Signature:_____ _____

Date:_____