— MISSISSIPPI —
PERIODONTICS
IMPLANTS & ESTHETICS

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NAME	DATE	REFERRING DENTIST
ADDRESS	CITY	ZIP
HOME NUMBER	CELL NUMBER	WORK NUMBER
DATE OF BIRTH	SS#	MARITAL STATUS
EMAIL ADDRESS	EMPLOYER	
SPOUSE/PARENT NAME	SPOUSE/PARENT EMPLOYER	
LAST PHYSICAL EXAM	PHYSICIAN	OFFICE NUMBER
EMERGENCY CONTACT	EMERGENCY CONTACT NUMBER	
DENTAL INSURANCE	INSURED NAME, DOB	INSURED SOCIAL

PRESENT DENTAL COMPLAINTS

HEALTH QUESTIONNAIRE (X "YES" OR "NO")

1. Other than checkups, have you ever been under the care of a physician in the last two years? YES ___ NO ___
2. Are you taking any blood thinning medications, such as ASPIRIN? Please list _____ YES ___ NO ___
3. Are you currently taking any medications, vitamins, or herbal remedies? Please list _____ YES ___ NO ___
   _____
4. Are you allergic or sensitive to any substance (pollen, soaps, food, LATEX, etc)? _____ YES ___ NO ___
5. Are you allergic to any drug or medication (penicillin, sulfa, codeine, local anesthetic, etc)? _____ YES ___ NO ___
   _____
6. Have you ever experienced excessive bleeding from a cut, injury, surgery or tooth extraction? YES ___ NO ___
7. Have you ever had radiation or chemo treatments of the head, neck, face or other areas of the body? _____ YES ___ NO ___
8. Do you have a surgical implant such as a PROSTHETIC HEART VALVE, PACEMAKER, OR ARTIFICIAL JOINT? _____ YES ___ NO ___
9. Do you take prophylactic antibiotics (SBE) prior to dental appointment? If so, what? _____ YES ___ NO ___
10. Are you pregnant? _____ Ever had cancer? _____ What type? _____ YES ___ NO ___
11. Have you ever taken medication for BONE DENSITY? If so, what? _____How long? _____ YES ___ NO ___
12. Do you smoke? _____ For how long? _____ YES ___ NO ___
13. Please (X) the following conditions that you have experienced or have been treated for:

__ANEMIA	__EPILEPSY OR SEIZURES	__LIVER DISEASE (HEP A, B OR C)
__ARTHRITIS	__FAINTING	__PNEUMONIA
__ASTHMA	__HEART ATTACK (CORONARY)	__PSYCHIATRIC COUNSELING OR TREATMENT
__AUTOIMMUNE DISEASE	__HEART MURMUR	__RHEUMATIC FEVER
__CONGENIAL HEART DEFECT	__HIGH BLOOD PRESSURE	__SHORTNESS OF BREATH
__CONGESTIVE HEART FAILURE	__HIV	__STROKE OR PARALYSIS
__DIABETES (TYPE 1 OR TYPE 2)	__IRREGULAR HEART BEAT OR PULSE	__THYROID CONDITION
__EMPHYSEMA	__KIDNEY OR BLADDER INFECTION	__ULCERS

OTHER_____

14. Have you had previous periodontic treatment? YES_____ NO_____ If yes, with whom? _____

May we have your permission to request additional medical information? Please sign _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Phone: _____ **Email:** _____

Patient Number: _____ **Social:** _____

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:

Office of Mississippi Periodontics, Implants & Esthetics

Phone: (769) 567-1250
Fax: (769) 567-1254
Email: info@msperiodontics.com
Address: 599A Steed Road, Ridgeland, MS 39157

Right to Revoke: **You will have the right to revoke this consent at any time by giving us written Consent 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 healthcare operations.

Signature: _____ Date: _____

**If this Consent form is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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FINANCIAL POLICY

Dental insurance is a contract between you and your insurance company. It is your responsibility to the extent and limits of your coverage, and to provide our staff with accurate information to process efficiently (i.e. insurance company address, phone number, etc.). It is not our place to enter into between you and your insurance company regarding deductibles, copayments, etc. other than to provide information. **We do not directly participate with any Insurance programs**; however, as a file your claim for payment. Certain conditions may apply to your financial arrangements that may authorization for release and assignment of benefits. Your signature below authorizes us to offer this applies to your situation. If we do not participate with your insurance, 100% of the total cost is time of treatment. If you are unable to pay 100%, options are available. Our staff will help you whatever paperwork is required. However, the ultimate responsibility lies with you for payment of any and all monies due.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

Our office will be happy to file insurance claims on your behalf, but there is no way we can guarantee payment for our services **(this is strictly between you and your insurance company).** We will refile **once** and provide dental/medical records or a letter of review once without any cost to you. Repeated claims and requests for records and letters to your insurance company places undue burdens on our staff cannot comply with.

Unpaid balances in your account are ultimately **your responsibility** and we will apply our payment policy to all unpaid balances. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

We hope this will clarify your situation with your insurance plan so that we can concentrate on your treatment. Thank you for your cooperation and understanding.

Sincerely,

Billing/Insurance Department

_____ _____

Patient Signature Date

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, or conducting and arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, FDA requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted Uses and Disclosures Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

HIPAA NOTICE OF PRIVACY PRACTICES

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law and prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **February, 1, 2023.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

MEDICARE OPT-OUT PRIVATE CONTRACT

If you will be participating in Medicare, Please read over the following:

As you may or may not know, Dr. Howard is not a Medicare provider. We have chosen to "Opt-Out" of the program as of April 27, 2015. Because Dr. Howard has chosen to Opt-Out from Medicare, We are required by the Federal Government to enter into a "Private Contract" with all Medicare eligible patients.

This contact between Dr. Howard and the patient (Medicare Beneficiary, referred to in this contract as "Patient") allows Dentist to provide treatment to Patient without being subject to Medicare limits. To do so, the law requires Dentist to "opt-out" of Medicare and that no Medicare claim be filed for the treatment of Patient by Dentist.

Dentist represents that Dentist [is] [is not] (strike one) excluded from participation under the Medicare program under 1128,1156 or 1892 of the Social Security Act; in addition, Patient and Dentist agree that Patient is not now facing an emergency or urgent health care situation.

By signing this contract, Patient does the following:

(i) Agrees not to submit a Medicare claim (or to request that Dentist submit a claim) for services or items supplied by Dentist, even if they are otherwise covered under Medicare

(ii) Agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Dentist, and understands that no reimbursement will be provided under Medicare for those services or items: (Patient will pay for such services at Dentist's usual rate in accordance with Dentist's payment policies)

(iii) Acknowledges the Medicare limits do not apply to amounts that Dentist may charge for such services or items:

(iv) Acknowledge the Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for items and services covered by this contract, because payment is not made under Medicare.

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of Dentist's current opt-out period. The expected expiration date is 2 years from the date signed.

_____ _____

Patient or Legal Representative Date