2182 Sandy Drive Suite 102, State College, PA 16803
814-234-4444
Fax: 814-954-5652
Email: info@dentistrybyaprildetar.com

Dear Patient,

On behalf of Dr. Detar and the entire staff here at Dentistry by April Detar, welcome to our office! We very much look forward to serving all your family's dental needs for many years to come. We appreciate the trust you have placed in us, and we will strive to provide the high quality of dental care that you expect.

Our mission is to be the best office for comprehensive dental health in State College, PA, giving our patients exclusive attention with the doctor, hygienist, and team, always striving to foster patient relationships based on mutual trust. We dedicate ourselves to staying on the cutting edge of technology and dentistry by continually attending higher educational classes at the world's most premier post-dental education institutes for advanced learning, allowing us to offer our patients not only general dentistry, but also specialty services in the comfort of our own dental chairs.

Our team is devoted to making your appointments as pleasant and enjoyable as possible. We take great pride in our ability to provide you with optimal dental care designed for your unique needs and desires. The first step toward complete oral health is a thorough examination and diagnosis. We want our patients to make informed choices by fully understanding any problems. Dr. Detar will review your dental needs with you at this appointment or have you return for a second appointment to provide treatment consultation.

We will make every effort to ensure your dental care is affordable. It is the patient's responsibility to provide payment in full at the time of service unless other financial arrangements have been arranged. Discounts are given when payment in full is made prior to any dental treatment. For our patients with extensive treatment needs, we work with a multiple lending institutions that offer convenient payment plans many are interest free. For your convenience, we accept Visa and Mastercard. If you have dental insurance, please bring your payment information with you to your first visit. We will work with you to assure that you receive the maximum benefits to which you are entitled. For those that do not have insurance, we offer an in-house Dental Care Membership Program.

We look forward to meeting you! Feel free to ask questions of our staff. We are all here to help you.

Thank you again for choosing our dental practice.

Sincerely,
April A. Detar

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PATIENT INFORMATION:

Patient Name: _________________________________ Gender: ______ Date of Birth: _________________

Home Address: ____

Mailing Address: ____

E-mail Address: ____

Phone: Home ___________________ Cell ______________________ Work __________________________

Employed By: _________________________________ Occupation: ________________________________

Social Security Number: _________________________ Subscriber ID #: _____________________________

Dental Insurance _______________________________ Group #: ___________________________________

Subscriber Name: ____

Secondary Dental Insurance ______________________Group #: ___________________________________

Subscriber Name: ____

Emergency Contact: ____

Phone: ___________________________________Relationship: ________________________________

How were you referred to our office?

____

SPOUSE INFORMATION:

Spouse Name: ____ Date of Birth: ____________

Employed By: _________________________________ Occupation: ________________________________

Phone: Cell ___________________________________ Work _____________________________________

Social Security Number: ____

The confidential information requested is important for your treatment and insurance claim. If there is anything else we need to know, please tell us.

Medical History

Last Name: ______________________ First Name: ______________________ Birthdate: ______________

Name of Medical Doctor: ____________________________________ City/State: __________________________

Emergency Contact ___________________ Phone _____________ Relationship __________________________

List all medications that you are now taking:

____ ____

____ ____

____ ____

____ ____

____ ____

Are you allergic to any of the following?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythomycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics (Dental)
- ☐ Metals or Jewelry
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Tylenol

Do you have any of the following medical conditions?

- ☐ Acid Reflux (GERD)
- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Back Problems
- ☐ Bacterial Endocarditis
- ☐ Bleeding (Abnormal/Excessive)
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain (Angina Pectoris)
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Cold Sores (Herpetic Lesions)
- ☐ Congential Heart Defect
- ☐ Cortisone Treatment/Medicine
- ☐ Cough (Persistent/Body)
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Difficulty Breathing/ Easily Winded
- ☐ Emphysema
- ☐ Enlarged Lymph Nodes
- ☐ Epilepsy or Seizures
- ☐ Fainting/ Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches (frequent)
- ☐ Heart Attack
- ☐ Heart Mumur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Hemophilia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Problems (Renal Disease)
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lyme Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Renal Dyalisis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Slow Healing Mouth Wounds
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disorder
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tobacco or Vape Use
- ☐ Tuberculosis
- ☐ Tumors (Head/Neck)
- ☐ Ulcers
- ☐ Venereal Infection
- ☐ Weight Loss (unexplained)

HOSPITALIZATIONS & SURGERIES -
Have you ever been hospitalized or had ANY surgical operations?

	YES	NO
Please list:	☐	☐

ALCOHOL & SUBSTANCES

	YES	NO
Do you use controlled substances?	☐	☐
Do you have an alcohol dependency?	☐	☐
Have you ever been, or are currently, under treatment for chemical dependency or substance use disorder?	☐	☐

WOMEN: Are you...	YES	NO
Pregnant/Trying to get pregnant?	☐	☐
Nursing?	☐	☐
Taking oral contraceptives or have contraceptive implant?	☐	☐

Signature ______________________ Today's Date ______________

NOTICE OF PRIVATE PRACTICES (NPP)

CLIENT RIGHTS, HIPAA AUTHORIZATIONS, USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address: 2182 Sandy Drive Suite 102, State College, PA 16803.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (“CLIA”) prohibits access, or information held by certain research laboratories. In addition, our provider me deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client’s medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition is the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual’s dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures

to dental oversight agencies and law enforcement officials must be suspended on their written representation that an accounting would likely impede their activities.

9. Dentistry by April Detar permits disclosures without patient authorization to public health or government authorities authorized to receive reports of child abuse or neglect, companies with products or activities subject to the FDA jurisdiction, an employer when requested by the employer to provide health care to an employee and if the provider has given written notice to the employee that PHI related to the workplace injury with be disclosed to the employer, social services agencies or law enforcement in cases of abuse, neglect or domestic violence if the individual agrees to the disclosure or the disclosure is expressly authorized by statute or regulation or the provider, in their professional judgement, believes the disclosure is necessary to prevent harm to the individual or other potential victim, a court through a court order.

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HIPAA

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

  I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PERMISSION TO DISCUSS DENTAL TREATMENT

If you may want a family member or friend to discuss your dental treatment with our office, we must have in writing permission/consent from you to do so. Please list any person you give Dentistry by April Detar, LLC permission/consent to discuss your dental treatment with:

** If the patient is a minor, we will discuss dental treatment with either parent or guardian**

Name of Family Members or friends that we can discuss dental treatment with:

____

Please select one of the following below:

_____ I hereby give permission/consent to Dentistry by April Detar, LLC to discuss all dental treatment with the following individuals: ____
____

_____ I do not wish Dentistry by April Detar, LLC to discuss any of my dental treatment with anyone other than me.

Name: __________________________ Signature: ___________________________________

Date: ____

FORM 1

PATIENT CONTACT PREFERENCE

Please indicate all ways in which you would prefer to be contacted by our office:

- Home Phone: ____________________________
  _____ Voicemail with detailed information.
  _____ Voicemail with call back number only.
- Cell Phone: __________________________
  _____ Voicemail with detailed information.
  _____ Voicemail with call back number only.
- Work Phone: ______________________________
  _____ Voicemail with detailed information.
  _____ Voicemail with call back number only.
- Written Correspondence
  _____ Mail information to my home address.
  _____ Mail information to my work/office address.
  _____ Max information to this number ___________________
  _____ E-mail information to this e-mail address __________________________
- Text Message
  _____ Text with detailed information.
  _____ Text with call back number only.
- Other ____

Patient/Guardian Signature: ____________________________________ Date: ______________

Patient Name / Relationship (If minor) ____

FORM 1

DENTISTRY BY APRIL DETAR

SIGNATURE ON FILE

- ☐ I AUTHORIZE USE OF THIS FORM ON **ALL** MY INSURANCE SUBMISSIONS.
- ☐ I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
- ☐ I UNDERSTAND THAT **I AM RESPONSIBLE** FOR MY DENTAL BILL.
- ☐ I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES.
- ☐ I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR.
- ☐ I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
- ☐ MY SIGNATURE ALSO APPLIES TO ALL DEPENDENTS LISTED ON MY INSURANCE PLAN.

SIGNATURE: ____

DATE: ____

Financial Policies and Release of Information

Thank you for choosing Dentistry by April Detar for your dental health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health.

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist in cost of dental care.

As a courtesy to our patients, we are happy to file claims on your behalf. To do this, you must provide us accurate and up- to-date insurance information.

Your estimated out-of-pocket expense is required at the time of service unless prior arrangements have been made. We accept Cash, Check, Debit Cards, Visa, MasterCard, and Wells Fargo.
Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement.

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed. We will attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact your insurance company if they have not paid within 30 days. Your treatment plan will include a breakdown of all applicable fees, and we will inform you of all cost before treatment is administered. If special arrangements are needed, please talk to our financial manager prior to receiving service.
Any account 60 days or older will assess finance charges at a rate of 1-1.5% per month, 18% per year.
If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

Missed Appointments: Your scheduled appointment time has been reserved specifically for you. If you are unable to keep an appointment, please notify us (even after hours) at least 24 hours in advance. Failure to notify us less than 24 hours before your appointment may result in a minimum broken appointment charge of $75.00.

Returned Checks: For checks returned to us, as unpaid by your bank, we will charge you a $35.00 fee.
Past Due Accounts: Overdue accounts will be referred to a collection agency if more than 90 days past due. If your account goes to collection; you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I certify that the information that I have provided is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform Dentistry by April Detar of any changes associated with my insurance status. I agree to make an in-full, prompt payment to Dentistry by April Detar when billed for any and all charges not covered or paid by insurance. I hereby assign and direct to pay any and all benefits for dental services under this claim to Dentistry by April Detar.

I authorize the release of any dental information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

Dentistry by April Detar has my authorization to charge my credit card for any current or past due personal balance upon receiving my verbal or written permission.

Patient/Guardian Signature: ______________________________________ Date ______________