Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the business manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information

I give my permission and understand that my Protected Health Information may be subject to outside review to one, several, but not limited to:
- Doctors and Staff, Insurance Companies, Federal and Local agencies, Claim Administrators, Pharmacy and Staff

-Or to comply with:
- Workers compensation laws, legal proceedings, public health requirements, Law enforcement, and as required by law

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____ _________________________

Patient or legally authorized individual signature Date

______________________________________ ________________________

Printed name if signed on behalf of the patient Relationship

(Parent, legal guardian, personal representative)

Notation, if any, by staff

This form will be retained in your medical record

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.

Weiand and Weiand DDS, PS respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of use and disclosures of protected health information for treatment, payment, and health operations.

For treatment:

Information obtained by an assistant, dentist, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you. We may also provide information to others that are providing you care. This will help them stay informed about your care.

For Payment:

We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For health care operations:

We use your medical records to assess quality and improve services. We may also use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff. We may contact you to remind you about appointments and give you information about treatment alternatives or other health related benefits and services. We may contact you to raise funds. We may use and disclose your information to conductor arrange for services, including: medical quality review by your health plan: accounting, legal, risk management, and insurance services: audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights:

The health and billing records we create and store are the property of the practice. The protected health information in it, however generally belongs to you. **You have a right to**: Receive, read, and ask questions about this Notice;: ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted; request and receive from us a paper copy of the most current Notice of Privacy Practices for protected health information ("Notice") Request that you be allowed to see and get a copy of your protected health information. You may make this requesting writing. We have a form available for this type of request. Have use review a denial of access to your health information—except in certain circumstances; Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records. When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months. Ask that your health information be given to you by another means or at another location Please sign, date, and give us your request in writing. Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance. For help with this right during normal business hours please contact

Our Responsibilities

We are required to: keep your protected health information private; Give you this Notice; Follow the terms of this Notice. We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To ask for help or complain

If you have questions, want more information, or want to report a problem about the hand ling of your protected health information, you may contact:

Weiand & Weiand, D.D.S.
1414 N. Vercler Rd. Bldg 6
Spokane, Washington
509-926-1589

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our Business manager at our practice. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other disclosures and sues of protected health information

Notification of family and others.

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relieve efforts (Hospitals) information may be provided to people who ask for you by name. We may use and disclose the followi8ng information in a hospital directory: your name, location, general condition, and religion (only to clergy) You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:
With medical researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project. To funeral directors/Coroners consistent with applicable law to allow them to carry out their duties. To organ procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs. To the food and drug administration (DA) relating to problems with food, supplements, and products. To comply with worker compensation laws—if you make workers compensation claim. For public health and safety purposes as allowed or required by law: to prevent or reduce a serious, immediate threat to the health or safety of a person or the public. To public health or legal authorities to protect public health and safety to prevent or control disease, injury, or disability to report vital statistics such as births or deaths. To report suspected abuse or neglect to public authorities. To correctional institutions if you are in jail or prison, as necessary for your health and the health and safety of others. For law enforcement purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime. For health and safety Oversight activities. For example, we may share health information with the department of health. For disaster relief purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others. For work related conditions that could affect employee health. For example, an employer may as to asses health risks on a job site. To the military authorities of US and foreign military personnel. For example, the law may require us to provide information necessary to a military mission. In the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order. For specialized government function. For example, we may share information for nation security purposes.

Other uses and disclosures of protected health information
Uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.

Effective Date:
March 20, 2019 **Weiand & Weiand DDS, PS**

Patient Registration

Today's Date: ________________________

Patient's Name: ____

Circle one: Married Single Child Widow Separated Sex: M F

Soc. Sec. # _______ _____ _______ Birth date: _____________

Home Address: ____

City: ________________________ State: ___________ Zip: ____________

Home ph #__________________________ Cell Ph. # __________________________

email ___________________________________

Best way to contact you (circle one) home phone email cell phone text

Your employer: ___________________________________ Work phone # ________________________

Person responsible for account ________________________________

If child above please fill out below:

Parents Name: _____________________ Sex M F Birth date: ___________________

Home Address: _______________________________________

City: ________________ State: ___________ Zip: ____________

Circle one: single married separated widow Soc. Sec. # _______ ________ __________

Home ph #__________________________ Cell Ph. # __________________________

email ___________________________________

Your employer: ___________________________________ Work phone # ________________________

Emergency contact: ___________________________ Phone # _____________________________

Whom may we thank for referring you? ____

Dental Insurance Information

Primary Insurance

Insured's name: ________________________ Insured's employer: ___________________________

SS# _________________________________ Date of Birth: ___/_____/__________

Insurance company: ___________________________ Policy # ___________________________

2nd Insurance plan:

Insured's name: ________________________ Insured's employer: ___________________________

SS# _________________________________ Date of Birth: ___/_____/__________

Insurance company: ___________________________ Policy # ___________________________

Dental History

Please check any of the following problems that appy to you:	Yes	No
-Sensitivity (hot, cold, sweet, pressure)	□	□
Where? UR LR UL LL		
-Headaches, earaches, neck pain	□	□
-Jaw joint pain	□	□
-Teeth or fillings breaking,loose,shifting	□	□
-Grinding or clenching teeth	□	□
-Bleeding, swollen or irritated gums	□	□
-Are you experiencing pain	□	□
-Serious/difficult problems past dental work	□	□
Do you have or have you had any of the following?		
-Dentures	□	□
-Partial Dentures	□	□
-Braces/Orthodontic treatment	□	□
-Periodontal (gum) treatments	□	□

PLEASE SHARE THE FOLLOWING DATES:

-Your last cleaning ____/_____

-Your last complete x-rays ____/_____

- Your last dental exam ____/_____

Name of previous Dentist ___________________________

City ______________________ State ________________

Phone number ______________________________

	Yes	No
If you could whiten your teeth for a cost anyone could afford would you do it?	□	□
Do you smoke or use chewing tobacco?	□	□
How much?___ For how long? ___		
If I could change my smile, I would:		
-Make it whiter	□	□
-Make it straighter	□	□
-Close spaces	□	□
-Replace black metal fillings with tooth colored restorations	□	□
-Repair chipped teeth	□	□
-Replace missing teeth	□	□
-Replace old crowns that don't match	□	□
-Have a smile makeover	□	□

ON A SCALE of 1-10, WITH 10 BEING THE HIGHEST

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you **want** your dental health do be?

1 2 3 4 5 6 7 8 9 10

	Yes	No
Do you have any disease, condition, or problem not listed above that you think we should know about?	□	□

Please explain any questions that you answered yes to:

____

____

____

____

What is the most important thing to you about your future smile and dental health?

____

What is the most important thing to you about your dental visit today?

____

Consent: The undersigned herby authorizes Dr. Weiand to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Weiand to make a thorough diagnosis of the patients dental needs. I also authorize Dr. Weiand to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above.

____ _____________________

Patient Signature (Parent if child) Date

Please Print Name: ____

Turn Over →

Medical History

Has your physician or previous dentist recommended that you take antibiotics prior to dental treatment? yes no

Please check any of the following problems/conditions that apply to you:

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	□	□	Currently Pregnant/Nursing	□	□	Liver Disease	□	□
Allergies (seasonal)	□	□	Diabetes type 1 or 2	□	□	Mitral Valve Prolapse	□	□
Abnormal Bleeding	□	□	Dizziness/Fainting	□	□	Nervousness/Depression	□	□
Anemia	□	□	Drug/Alcohol Abuse	□	□	Pacemaker	□	□
Artificial Heart Valve	□	□	Epilepsy	□	□	Phen-fen or Redux taken	□	□
Artificial Joints (knee/hip)	□	□	Glaucoma/ Eye Surgery	□	□	Rheumatic/Scarlet fever	□	□
Arthritis	□	□	Heart Conditions	□	□	Seizures	□	□
Asthma	□	□	Heart Murmur	□	□	Stroke	□	□
Bisphosphonate(Fosamax)	□	□	Hepatitis A B or C	□	□	Thyroid Disease	□	□
Cancer	□	□	High/Low Blood Pressure	□	□	Tuberculosis	□	□
Chemotherapy	□	□	Kidney Disease	□	□	Ulcers	□	□
Other: ___________________			__________________________________	□	□			

Allergies: Are you allergic to or have you had a reaction to:

	Yes	No		Yes	No		Yes	No
Aspirin	□	□	Local(dental) anesthetics	□	□	Sulfa Drugs	□	□
Codeine	□	□	Nitrous Oxide	□	□	Tetracycline	□	□
Latex	□	□	Penicillin or other antibiotics	□	□	Valium	□	□
Other ____							□	□

What medications are you currently taking? ____

Are you under a physician's care? □ □
What for?_____________________________________

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of your financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard and Visa. Outside financing is available upon request and approval.

Do you have insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
– All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
– Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
– We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
– We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, or Visa at the time we provide the service to you.
– Insurance payments are ordinarily received within 20 to 40 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment in not received or your claim is denied, you will be responsible for paying the full amount at that time.
– We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENIFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payments for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, or collection charge will be added to any overdue balance.

____ ______________________________

Patient Signature (parent if child) **Date**