PATIENT INFORMATION

DATE _____

NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____ PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT:

_____

NAME ADDRESS PHONE

EMPLOYED BY _____

BUSINESS ADDRESS _____ PHONE _____

DENTAL INSURANCE _____

S.S. # (if insured) _____

CASH _____ VISA _____ MASTERCHARGE _____ DISCOVER _____

DENTAL HISTORY

PREVIOUS DENTISTS 1. _____ 2. _____ 3. _____

WHAT IS YOUR CHIEF DENTAL COMPLAINT? OR PROBLEM? _____

ABOUT HOW LONG HAS IT BEEN SINCE YOU LAST SAW A DENTIST? _____ YEARS

ANY PREVIOUS PROBLEM WITH DENTAL EXPERIENCE? _____

REFERRED OR SENT TO THIS OFFICE BY _____

MEDICAL HISTORY

(PLEASE DESCRIBE AND/OR ANSWER THE FOLLOWING):

HAVE YOU HAD ANY MEDICAL PROBLEMS?	YES	NO	DESCRIBE: _____
HAVE YOU ANY ARTIFICIAL HEART VALVES OR ARTIFICIAL JOINTS?	YES	NO	DESCRIBE: _____
RHEUMATIC FEVER?	YES	NO	DESCRIBE: _____
AIDS?	YES	NO	DESCRIBE: _____
HAVE YOU HAD PROSTATE TROUBLE OR GLAUCOMA?	YES	NO	DESCRIBE: _____
ANEMIA (SICKLE CELL)?	YES	NO	DESCRIBE: _____
ARE YOU PREGNANT?	YES	NO	DESCRIBE: _____
MEDICATION?	YES	NO	DESCRIBE: _____
HIGH BLOOD PRESSURE?	YES	NO	DESCRIBE: _____
HEART TROUBLE?	YES	NO	DESCRIBE: _____
CARDIAC PACEMAKER?	YES	NO	DESCRIBE: _____
ALLERGY TO MEDICATION?	YES	NO	DESCRIBE: _____
DIABETES?	YES	NO	DESCRIBE: _____
LIVER, KIDNEY, OR HEPATITIS?	YES	NO	DESCRIBE: _____
PSYCHIATRIC?	YES	NO	DESCRIBE: _____
SINUS TROUBLE?	YES	NO	DESCRIBE: _____
THYROID?	YES	NO	DESCRIBE: _____
LUNG OR RESPIRATORY?	YES	NO	DESCRIBE: _____

SIGNATURE _____ DATE _____

(Parent or guardian, if patient is a minor)

MEDICAL ALERT ►

NAME ______________________________

DATE	SERVICES RENDERED	ACCOUNT RECORD		
		CHARGE	PAID	BALANCE

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for the contemplated dental treatment. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and direct Dr. Chris Doucet with associates or assistants of his choice to perform upon _____,the following diagnostic, surgical or dental procedures:

Please circle:

Extraction	Root Canal	Full or Partial Dentures
Fillings	Crowns or Bridges	Cleaning
Bonding(cosmetics)	Periodontal Treatment	Other:_____

including any necessary or advisable anesthesia.

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:

Alternatives to the recommended treatment, including no treatment, have been explained to me, as have the advantages and disadvantages of each.

RISKS ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:

I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A partial listing of the risks known to be associated with this treatment and with the associated anesthetic are:

- Swelling & Bruising which may necessitate staying home for several days
- Retained Instrument Fragment(s)
- Paresthesia (Permanent or transient numbness of the cheeks, gums, teeth, lips, tongue, chin, and face)
- Change in the bite
- Loss of Taste
- Swallowing of Objects
- Aspiration of Objects
- Drug/Allergic Reaction
- Dry Socket (post extraction infection)
- Stretching of mouth which may result in cracking or bruising
- Failure of the treatment to accomplish its purpose
- Bleeding which may be heavy enough to stop the procedure
- Instrument Breakage
- Infection
- Pain
- Breakage of Root(s)
- Retained Root Fragment(s)
- Loss/Damage to Adjacent Teeth and Bone
- Fracture or Breakage of Jaw
- Sinus Involvement
- TMJ Dysfunction of worsening of TMJ Condition
- Trismus (Jaw pain or difficulty opening mouth)
- Further surgery or treatment

(over)

(Continued)

State law also requires that I specifically advise you that, although rarely occurring, the dental treatment or anesthetic may result in: Death, Brain Damage, Quadriplegia, Paraplegia, Loss of Organ(s), Loss of Function of an Organ, Loss of Function of Face, Arm(s) or Leg(s), and disfiguring Scars.

ACKNOWLEDGMENT

I acknowledge that I have read and I understand the information on both pages of this consent form (or that it has been read to me). I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about the treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand that the success of this treatment and the avoidance of treatment complications depends to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my following the instructions given to me, and my keeping the appointments for treatment or follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complication(s), where further treatment may be discussed, or administered, which is not currently anticipated.

I hereby authorize and direct Dr. Chris Doucet and/or associates or assistants of his choice, to perform the diagnostic, surgical or dental treatments. This consent form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive any further disclosures or information.

Date_____

Signature of Patient_____

Signature of Relative (where required)
or Guardian_____

Patient was questioned as to his/her understanding of the contents of this consent and fully understands same without limitations.

Signature of Witness_____

_____
Dentist

OUR FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your health care provider. The following is or Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, and for your convenience, MasterCard, Visa and Discover. We will be happy to help you process your insurance claim for your reimbursement as long as you bring a completed claim form at each visit.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or arbitrarily select UCR (usual and customary rates) for certain benefits.

3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up.

5. If the insurance company does not pay in full within 45 days, we require you to pay the balance due with cash, check, MasterCard, Visa or Discover.

6. Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges of 1 1/2% per month.

Please note that, unless canceled at least 24 hours in advance, you may be charged for missed appointments at the rate of a normal office visit. Please call if you have to reschedule.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient's Signature _____ Date _____

CHRISTOPHER E. DOUCET, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security # _____

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:

Contact Person: Iris Lastrapes

Telephone: 942-4588 Fax: 948-1341

E-mail: _____

Address: 906 N. Union St., Opelousas, LA 70570

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice 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 fully 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 health care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____Date:_____

CHRISTOPHER E. DOUCET, D.D.S.

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described on this Notice while it is in effect. This Notice takes effect_____/_____/_____, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation wil not effect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without you written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that your are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____for each page, $_____per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Iris Lastrapes

Telephone: 942-4588 Fax: 948-1341

E-mail:

Address: 906 N. Union St., Opelousas, LA 70570
