Lake Nona Dental Implants and Periodontics

Dr. Carlos Pires DMD, MSD

PATIENT INFORMATION:

Name: _____
Last ***first*** ***middle***

Address:_____
Street *City* *State* *Zip*

Cell phone: _____ Home phone: _____ Work phone: _____

Email: _____ Employer: _____

Social Security #: _____ Date of Birth: _____ ( ) Male ( ) Female
mm/dd/yyyy

Height: _____ Weight: _____ ( ) Single ( ) Married ( ) Widowed ( ) Divorced

IF PATIENT IS A MINOR OR LEGALLY INCAPACITATED *(please provide proper documentation):*

Parent/Guardian: _____ Relation to Patient: _____

Address: _____
Street *City* *State* *Zip*

Phone #: _____ Email: _____

EMERGENCY CONTACT: _____ Relation: _____ Phone #: _____

DENTAL INSURANCE INFORMATION:

Primary Insurance Co.: _____ Policy in the name of: _____

Relation to Patient: _____ Date of Birth: _____ Insurance ID/SS:_____
mm/dd/yyyy

Employer: _____ Group #: _____

DENTAL HISTORY:

Who is your General Dentist? _____

How did you hear about us? _____

Reason for visit: _____

Have you ever had treatment for gum problems? ( )Yes ( )No if yes: _____

What would you like to improve or change about your oral health/teeth? _____

MEDICAL HISTORY:

Physician's name: _____ Phone #: _____ Date of last visit: _____

Are you currently under a doctor's care? ( )Yes ( )No If yes, explain:_____

Date of last hospitalization: _____

Do you smoke? ( ) Yes ( )No - If yes, How much? ____ Packs daily _____ Years

Do you bleed excessively when cut? ( )Yes ( )No

Do you need to be premedicated prior to dental treatment? ( )Yes ( )No

Are you pregnant? ( )Yes ( )No Are you nursing? ( )Yes ( )No Are you taking birth control pills? ( )Yes ( )No

Are you allergic to or do you suffer ill effects from any of the following or others? ( )No ( )Yes - Check all that apply:

( ) Penicillin ( ) Codeine ( ) Dental Anesthesia ( ) Latex ( ) Household Bleach ( ) Aspirin

Other allergies:_____

Have you had or do you have, or suspect to have, or use any of the following? Please check all that apply:

( ) Heart Murmur/Mitral Valve Prolapse	( ) High Blood Pressure	( ) Low Blood Pressure	( ) Cancer
( ) Congenital Heart Defect	( ) Glaucoma	( ) Malignancy	( ) Blood Disorder
( ) Epilepsy/Seizures/Fainting	( ) Recreational Drugs	( ) Thyroid Disorder	( ) Anemia
( ) Radiation or Chemotherapy	( ) Diabetes	( ) HIV +/AIDS	( ) Liver Disease
( ) Psychiatric Problems or Depression	( ) Pacemaker	( ) Stroke	( ) Hepatitis
( ) Digestive Disorders	( ) Venereal Disease	( ) Drug Addiction	( ) Kidney Disease
( ) Chemical/Drug Dependency	( ) Metal Allergy	( ) Scarlet Fever	( ) Tuberculosis
( ) Alcohol Abuse/Dependency	( ) Asthma	( ) Sinus Problems	( ) Hay Fever
( ) Head and Neck Pain	( ) TMJ	( ) Rheumatic Fever	( ) Arthritis
( ) Severe/Frequent Headaches	( ) Heart Surgery	( ) Fever Blisters/Herpes	( ) Ulcers
( ) Artificial Joints or Valves	( ) Emphysema	( ) Heart Attack	( ) Shingles
( ) Hemophilia/Abnormal Bleeding	( ) Blood Transfusion	( ) Difficult Breathing	( ) Colitis

Please indicate any other serious illness not listed above: _____

Check any of the following that you are taking or have taken:

( ) Cortisone Drugs ( ) Anticoagulants ( ) Tranquilizers ( ) Steroids

( ) Blood Thinners ( ) Sedatives ( ) Hormone Therapy ( ) Birth control Pills/Shots/Implant

Please list ALL other medications that you are taking: _____

_____

_____

INFORMED CONSENT

I have read, understood and accurately completed the above information including the statements regarding my medical conditions. Further, I authorize and give permission to the doctor(s), hygienists and staff of this dental practice to perform all treatment(s) agreed between doctor and patient, and/or parent/guardian, as recommended by the doctor, including the use of X-rays, CT scan, anesthetics and other medication(s) as indicated and necessary to complete my dental/periodontal treatment. I accept responsibility to pay the full amount of all fees whether or not payable by dental insurance.

I have read, understood and I fully agree to the above terms and conditions.

_____ _____

Patient Signature Date

_____ _____ _____

Parent/Legal Guardian Signature Relation to patient Date

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TREATMENT PLAN AND APPOINTMENT POLICY

Dental procedures require preparation and planning. This includes appropriate staffing, treatment room availability and material preparation. We reserve specific time blocks in an attempt to meet patient schedules and the urgency of the dental need. **If you have made an appointment with us, that time has been reserved exclusively for you and we have prepared in advance for your visit.** Please be advised of the following requirements:

- Treatment plan(s) are valid for up to 90 (ninety) days from the day it is presented to the patient, if the treatment(s) is not scheduled within 90 days, prices are subject to change and a new treatment plan will have to be issued.
- A deposit of 50% is required to schedule your treatment appointment. This deposit will be credited towards the cost of the dental/periodontal services rendered on the date of the appointment. Late cancellation or no-show fees will apply, see below:
- If you are unable to keep your appointment, we require **at least 48 hours notice**; this will enable us to schedule other patient for that time and to reschedule your appointment at a more convenient time for you.
    - REGULAR OFFICE VISITS/MAINTENANCE: **cancelled with less than 48 hours notification, or no shows** may be subject to a $50.00 cancelation fee.
    - SURGICAL APPOINTMENTS: **cancelations with less than 48 hours notification, or no shows** may be subject to a $100.00 cancellation fee.
- The Cancelation and No Show fees are the sole responsibility of the patient or responsible party and must be paid in full before the patient's next appointment.
- If a patient has 3 (three) no shows or cancelled appointments without the required notice (above described), we reserve the right to not schedule any further appointments or to require that the no refundable fee(s) for the appointment and/or treatment is paid in full and in advance in order to schedule a future appointment.

I have read, understood, and I fully agree to this Treatment Plan and Appointment Policy.

Date: ___/___/_____

_____ _____

Patient Name (printed) **Signature**

_____ _____ _____

Responsible Party (printed name) **Signature** **Relation to Patient**

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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 10/08/2019, 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 in formation 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, such information may be disclosed electronically, in printing, via mail, and/or verbally. 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.
Treatment Photographs/Marketing. We may utilize photographs taken during treatment, such as before and after photos, for promotional or educational materials. These materials might include printed or electronic publications, such as fliers, folders, Websites, social media or other printed and/or electronic communication. We will not be obligated to pay and/or compensate you for any rights to use the photographs as mentioned above. **Your name and/or identity will not be made public without your prior written authorization.**
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.
Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders, such as phone calls, voicemail messages, text messages, postcards, letters, emails, etc., including the use of a third party company and/or an automated system.
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 protected health information 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 protected health information 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 protected health information 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 protected health information 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 protected health information 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 protected health information 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 protected health information 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 (Protected Health Information)
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of protected health information for marketing, and for the sale of protected health information. We will also obtain your written authorization before using or disclosing your protected health information 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 protected health information, 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 protected health information 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 (email).

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:

Karen Fiedler
Telephone: (407) 535-9802 Fax: (407) 501-7073
Address: 9145 Narcoossee Rd. ste. A100, Orlando, FL 32827
Email: lakenonaperiodontics@gmail.com

If needed we can provide a copy of this Notice in large prints.

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FINANCIAL POLICY

Payment is due in full at the time services are rendered.

We offer the following payment options:

- Cash, Credit Card (Visa, Mastercard, Amex, Discovery), CareCredit, LendingClub, and Check ($35.00 fee will be charged for any NSF check).

FOR PATIENTS WITH INSURANCE:

Insurance policies vary considerably, we may estimate your coverage, but **cannot** guarantee coverage or payment amounts by your insurance company, **estimates are not exact amounts**. We ask our patients to provide us with complete insurance information, so that they can best utilize their dental benefits and get reimbursed as quickly as possible.

***As* a courtesy, we will file the claim for reimbursement directly to you. Therefore, you are responsible for full payment at the time service(s) is rendered.**

We are always available to answer your questions about insurance to the best of our knowledge, however, your insurance policy is a contract between you and your insurance company, and we are not a part of that agreement. Our treatment recommendations are based on what we believe is the best for your oral health, and not on what the insurance will cover or not, insurances coverage are designed to cover minimal to standard care only.

THIRD-PARTY COLLECTION:

Any account 60 days past due may be sent to a collections agency. By signing this financial consent you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of up to 50% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

INFORMED CONSENT

I agree to be fully responsible for the total payment of treatment(s) rendered to me at this office, whether or not covered by insurance. I have read and fully understand and agree to all terms and conditions in this Financial Policy.

_____

Print Patient's Name

_____ _____

Signature **Date**

IF THE FINANCIALLY RESPONSIBLE PERSON IS NOT THE PATIENT:

As the **Responsible Party** I have read and fully understand and agree to all terms and conditions in this Financial Policy. I agree in continuing paying in full for all treatment(s) rendered at this office to the patient mentioned above, whether or not covered by insurance. I understand that I have the right (except if the patient is your legal dependent) to request in written to no longer be the financially responsible person for this patient, except for the extent of treatment(s) that have been already rendered relying on this consent.

_____ _____ _____

Responsible Party (print name) **Signature** **Date**

Soc. Sec. #: _____ Date of Birth: _____ Relation to Patient: _____

Address:_____

Street *City* *State* *Zip*

Phone #: _____ Email: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

The Notice of Privacy Practices describes how your protected health information may be used and disclosed and how you can get access to this information. Please review it carefully.

You may refuse to sign this acknowledgment.

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

Patient's Name (print): _____

Signature: _____

Date: _____

If signed by a legal representative:

Name:_____ Relation to 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) _____

_____