PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ **Sex**: ☐ Male ☐ Female **Are you?** ☐ Policy Holder ☐ Responsible Party

Whom may we thank for this referral? _____

Responsible Party (***if someone other than the patient***)

First Name: _____ Last Name: _____

Preferred Name: _____ ☐ Policy Holder ☐ Responsible Party

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Date of Birth: ___/___/___ Age: _____ Social Security: ___-___-___

☐ Primary Insurance Policy Holder Name: _____ ☐ Secondary Insurance Policy Holder Name: _____

Patient Information

Address: _____

City, State, Zip: _____

Home Phone: _____ **Work Phone:** _____ **Ext:** _____ **Cell Phone:** _____

Date of Birth: ___/___/___ **Age:** _____ **Social Security**: ___-___-___

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed **Spouse Name**: _____

Email: _____ ☐ *I would like to receive correspondences via e-mail*

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Patient/Parent Employed By: _____ Present Position: _____ How long held: _____

Spouse Employed By: _____ Present Position: _____ How long held: _____

Method of Payment: ☐ Cash ☐ Credit Card ☐ Check

Emergency Contact

Someone to notify in case of emergency not living with you: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

At my request, _____ may release the following information:
(Name of the entity)

- ☐ Entire record
- ☐ Financial Records
- ☐ Other as listed
- ☐ X-Rays or Photos
- ☐ Office Visit Notes
- ☐ Marketing*

_____

_____

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name _____

Address _____

City, State, Zip _____ Phone _____

☐ **Send the information electronically. Email address: _____**

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2014

JULIE PATTERSON LEDFORD, DDS, PA

- COMPREHENSIVE FAMILY DENTISTRY -

FINANCIAL GUIDELINES

We are honored you have given our team the opportunity to assist you with your dental care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering the following payment options.

- Cash, Check, Visa, MasterCard, Discover, American Express
- Payment plans through Care Credit, including 6 or 12 month no Interest if paid in full within promotional period plans. (requires credit approval)
- For those patients who have a dental benefit plan, we are happy to file your claims and estimate your payment due at each appointment. Remember that your coverage is a contract between you and your company and we cannot guarantee the amount insurance will pay for any procedure.

The parent or guardian accompanying children will be responsible for payment at time of visit.

Accounts with balances over 90 days past due will accrue interest at the rate of 1.5% per month. Legal fees incurred due to collection proceedings will be the patient's/guardian's responsibility.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

I have read, understand, and accept these Financial Guidelines.

_____

Patient Name (please print)

_____

Patient/Legal Guardian Signature **Date**

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Julie P. Ledford, DDS and staff are authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointments ☐ Dental or Medical Treatment ☐ Financial
☐ Other person (s) (provide name and phone number)	☐ Appointments ☐ Dental or Medical Treatment ☐ Financial
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Dental or Medical Treatment ☐ Financial ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedures)	☐ May be posted in office ☐ May be posted on website ☐ May be posted on Facebook

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

Pediatric Questionnaire

- **Does your child have trouble going to bed or falling asleep?** Yes / NO
- **Awaken during the night and have trouble returning to sleep?** Yes / NO
- **Does he/she tend to breathe through their mouth during the day or during sleep?**

  Yes / NO

- **Have dry mouth or bad breath upon waking in the morning?** Yes / NO
- **Have you noticed any of the following while your child is sleeping?**
  - Snoring, heavy or loud breathing Yes / NO
  - Break or pause in breathing Yes / NO
  - Gasp, choke, or struggle to breathe Yes / NO
  - Restless or agitated sleep? Grinding teeth? Yes / NO
  - Abnormal head posture (hyper-extension, etc.) Yes / NO
  - Excessive sweating Yes / NO
  - Wetting the bed Yes / NO
- **Have you noticed any of the following during the day?**
  - Difficulty waking Yes / NO
  - Wakes with headaches Yes / NO
  - Groggy, tired or "out of it" Yes / NO
  - Hyperactive Yes / NO
  - Teachers commented Yes / NO
  - Does not seem to listen when spoken to directly Yes / NO
  - Has difficulty organizing tasks Yes / NO
  - Easily distracted by extraneous stimuli Yes / NO
  - Fidgets with hands or feet or squirms in seat Yes / NO
  - Interrupts or intrudes on others Yes / NO
- **Is your child frequently sick, have a history or sore throat, ear infections, sinus infections, or allergies?**

  Yes / NO

- **Has patient stopped growing at a normal rate at any time since birth? Overweight?**

  Yes / NO

- **Habits such as: pacifier / thumb sucking / lip biting / other?**

Julie P. Ledford, DDS, PA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY [Practice Name] AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Privacy Officer Julie P. Ledford
drjulieledford@gmail.com
(828)389-8714
Effective date: April 14, 2003 Revision Date: March 26, 2013

JULIE P. LEDFORD, D.D.S., PA

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____ Date of Birth:_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature_____ Date:_____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:_____
  _____
- Other:_____
  _____

Prepared by:_____

Signature:_____

Date:_____