

Drs. Chapman & Puderbaugh, D.D.S., P.L.L.C.
NOTICE OF PRIVACY & SECURITY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED &
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 & state law to maintain the privacy & security of your health information. We are also required to give you this Notice about our privacy & security practices, our legal duties, and your rights concerning your health information. We must follow the privacy & security practices that are described in this Notice while it is in effect. This Notice takes effect March 2, 2009 and will remain in effect until we replace it. We reserve the right to change our privacy & security 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 policy & security 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 policy & security 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 & security 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 at any time. Your revocation will not affect 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 location) 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 to 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 your 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 the appropriate authorities if we reasonably believe that you 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 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, messages with co-workers or family members, 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 practically 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 correct information listed at the end of this Notice. We will charge you reasonable cost-based fee for expenses such as copies and staff time. 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 your agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternate 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 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy & security practices or if you have any questions or concerns, please do not hesitate to contact us.

If you are concerned that we may have violated your privacy & security 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 may also 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 upon request. We support your right to the privacy & security 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: Deana Branham, CDPMA Telephone: 744-1251 Fax: 744-1279 Address 308 C Street South Charleston W.V. 25303

Drs. Chapman & Puderbaugh DDS, PLLC
CONSENT FOR USE AND DISCLOSURE OF HEALTH
INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____ **SOCIAL SECURITY#:** _____

SECTION B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENT 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 the healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you 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 & security 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 may 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: Deana Branham

TELEPHONE: (304)744-1251 **FAX:** (304)744-1279

ADDRESS: 308 C Street South Charleston WV 25303

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.

I, _____, have had full opportunity to read and consider the
Please Print Name
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.

Drs. Chapman & Puderbaugh DDS, PLLC

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY & SECURITY PRACTICES**

You may refuse to sign this acknowledgement

**I, _____ have received a copy of the
Notice of Privacy & Security Practices.**

Signature

Date

For Office Use Only

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy & Security Practices, but
acknowledgement could not be obtained because:**

- Individual refused to sign**
- Communication barriers prohibited obtaining the acknowledgement**
- An emergency situation prevented us from obtaining acknowledgement**
- Other (Please Specify)**

Patient Information

Patient Name: _____ Date: _____
(Preferred Name)
Married: ___ Single: ___ Child: ___ Other: ___ Male: ___ Female: ___
Social Security #: _____ Birth Date: _____ Drivers License #: _____ Email: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____ Best time to call: _____
Preferred appointment times: Morning Afternoon Evening Any Time
Address: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Novocain Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | Other Drug Allergies |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Other Anesthetic |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | Allergy _____ |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Do you smoke? |

• **PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN:**

• Name, relationship & phone number of person to contact in case of emergency?

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages School Work Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment same information as other side of form

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Insured's Employer Name: _____
Address: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Insured's Employer Name: _____
Address: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare & file the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for any dental care can only be extended for a period of six months from the date of the patient examination.

I agree to be responsible for all services & materials not paid by my insurance plan, unless Drs. Chapman & Puderbaugh have a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information related to any of my immediate family members' insurance claims or my own. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or my account. I authorize payment of all benefits otherwise payable to me directly to: Drs. Chapman & Puderbaugh DDS, PLLC. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Drs. Chapman & Puderbaugh DDS, PLLC

Insurance and Financial Policy

Here at Drs. Chapman & Puderbaugh’s office, we believe that you deserve the best care. That’s why we always present you with the best dental solution possible to treat your personal situation. We strive to provide outstanding dental care to hundreds of patients throughout the year. Some have dental benefits but some don’t. If you have dental benefits, congratulations! You are very fortunate but whether or not, here are some important things you should know:

Initial

_____ If you have dental benefits, they are based upon a contract between your employer and an insurance company. If you have questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care, it is only meant to assist you. Please be prepared to pay any deductibles, co-payments, or deposits at the time services are rendered.

_____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service) and participate with a few plans as well. This means that we work literally with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit we will be happy to file a “pre-treatment estimate” with your insurance company prior to treatment. Keep in mind however, that this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, our office reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ We require payment in full for your portion at the time of service. We accept Visa, MasterCard, Discover, American Express, cash & checks (for existing patients with established payment history). If you need an extended finance option, we also work with CareCredit, who offers 3,6, and 12 month “same as cash” or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **\$35/hour cancellation fee** (emergencies are an exception).

_____ In the event of an emergency after regular business hours a **\$61 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **\$125 after hours emergency fee**.

I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Parent Signature: _____