Other

Who were you referred by? ____________________

Emergency Contact ____________________ Relationship __________

Emergency Contact Phone # ____________________

Are other members of your family patients at this practice? If so, please list:

Name	Relationship
______________	______________
______________	______________
______________	______________
______________	______________

Authorization To Treat and Insurance Authorization

All professional services rendered are charged to the account holder. *Payment, in full, is due when services are rendered.* If you have dental insurance, we will file as a courtesy. You are responsible for your percentage at the time services are rendered. The account holder is responsible for all fees regardless of insurance coverage.

I authorize Tampa Rhodes- Bell, DMD, LLC to furnish information to insurance carriers concerning my treatment. I assign to Tampa Rhodes-Bell, DMD, LLC all payments for dental services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by assigned insurance. I have read all the above and give Tampa Rhodes- Bell, DMD, LLC permission to treat me/my child.

Signature ____________________ Date ____________________

Patient Registration

Tampa Rhodes- Bell, DMD

Please complete the following confidential information.

Patient Information

Date ____________________

Name ____ Date of Birth ____________________

Single ____________ Married ____________ Divorced ____________ Widowed ____________

Male ____________ Female ____________

If Child, Please give parent(s) name: ____

Street Address ____

City, State, Zip ____

Home Phone # (______) ____________________ Office Phone # (______) ____________________

Cell Phone # (____) ____________________ Email Address: ____________________

Patient's Social Security # ____

Account Information (Person financially responsible for account)

Name ____ Relationship to Patient ____________

Date of Birth ____________________ Social Security # ____________________

Mailing Address ____

City, State, Zip ____

Home Phone # (______) ____________________ Office Phone # (______) ____________________

Cell Phone # (____) ____________________ Email Address: ____________________

Dental Insurance Information

Employer ____ Insurance Company ____________

Insured's Name ____ Insured's Date of Birth ____________

Insured's ID# or SS# ____ Group # ____________________

Health History

Patient's Name ____________________
(Please Print)

Are you in good health?? Yes No

Are you taking any medications now? Yes No
If yes, what medication? ____________________
____

Do you have or have you ever had any of the following:
(Circle all that apply)

Heart disease
Coronary bypass
Heart attack/angina
Mitral valve prolapse
Rheumatic fever
Heart pacemaker
Heart surgery
Aids/HIV+
Hepatitis A (Infectious)
Hepatitis b (Serum)
Liver disease
Yellow jaundice

Emphysema
High blood pressure
Tuberculosis
Heart murmur
Artificial joint
Diabetes
Stroke
Kidney disease
Ulcers
Sickle cell disease
Thyroid disease
Seizures/Epilepsy

Sinus trouble
Psychiatric treatment
Arthritis
Jaw joint pain
Dizzy spells
Cancer
Asthma
Cold Sores/ Fever Blisters
Blood transfusion
Sexually transmitted disease
Anemia
Calcium Deficiency

Are you allergic to any of the following:
(Circle all that apply)

Penicillin
Codeine
Aspirin

Erythromycin
Local anesthetic
Ampicillin

Novocain
Tetracycline
Latex products

Have you had abnormal bleeding associated with extractions? Yes No

Do you use tobacco products? Yes No

FOR WOMEN ONLY:
Are you pregnant or attempting to become pregnant? Yes No

Are you taking birth control pills? Yes No

Are you on hormone replacement therapy? Yes No

Signature ____________________ Date ____________________

Financial Policy and Agreement

Welcome to our office! Our goal, as it pertains to the cost of treatment, is to help remove financial barriers so our patients can receive the dental treatment they need and desire. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

Insurance: Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, we can only estimate in good faith, not guarantee coverage. ***Your estimated patient portion must be paid at the time service is rendered.*** As a service to our patients, we will bill your insurance company for services and allow 45 days for them to render payment. After 60 days, you are responsible for the entire balance and it will be due in full. If you have any questions, our courteous staff is always available to answer them.
You will be informed of the treatment planned and associated fees. Patients are responsible for charges for dental services and materials not paid by their dental benefit plan. To the extent permitted by law, patient consents to the use and disclosure of protected health information to carry out payment activities in connection with filing of the dental insurance claim(s). By signing below, you are authorizing direct payment of dental benefits, otherwise payable to you, directly to Carrollton Dental Solutions.

Payment Options: Patients are asked to pay for services as they are provided and ***all account balances are to be paid within 90 days unless prior written arrangements have been made.*** We accept cash, checks, debit and most major credit cards. We also offer flexible financing options because we understand monthly payments can help patients fit the cost of dental treatment into their budgets. Any financial arrangements **must be made prior to starting treatment.**

CareCredit®Financing: We offer financing through CareCredit for those who qualify. With CareCredit, you can finance 100% of your dental treatment and there are no upfront costs, no annual fees, and no pre-payment penalties. CareCredit offers a full range of payment plans so you can find one that works well for you. CareCredit also allows for revolving payments with variable interest rates and up to 12 months of 0% interest. It can be used by the entire family for ongoing treatment without having to reapply.
Please call at least two business days in advance for changed appointments. Missed appointments without this notification, or repeated cancellations, may incur cancellations fees. We want to work with you to schedule convenient appointments for your visits to our office.

Service Charges: The policy of this office is to charge 1% monthly interest (12% APR) or a billing charge that will be applied to all accounts over 90 days past due. We will charge $35 for returned checks.

Collection Fees: Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent: The patient (account holder) agrees to be fully responsible for total payment of treatment rendered in this office.
I understand and agree to this Financial Policy and Agreement.

____

Signature of Patient/Responsible Party **Date**

Mableton Dental Care, LLC
1025 Veterans Memorial Hwy SE, #320, Mableton, GA 30126
Phone: 678-945-1708
Fax: 678-945-1733
Email: mabletondentalcare@gmail.com
Practice Manager: Nicole Marie

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Mableton Dental Care, LLC Notice of Privacy Practices.

Patient name ______________________________

Signature ______________________________ Date ______________

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me to the following people:

Name ______________________ Relationship ______________ Phone __________

Name ______________________ Relationship ______________ Phone __________

Name ______________________ Relationship ______________ Phone __________

Name ______________________ Relationship ______________ Phone __________

or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get

Effective date of notice: 02/01/2018

NOTICE OF PRIVACY PRACTICES

Mableton Dental Care, LLC
1025 Veterans Memorial Hwy SE #320
Mableton, GA 30126
Phone: 678-945-1708
Fax: 678-945-1733
Email: mabletondentalcare@gmail.com
Practice Manager: Nicole Marie

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is

an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.