

Patient Information Form

| | |
|---------------------------------|----------------------|
| Name: | |
| Spouse or Parent's Name: | |
| Address: | |
| Social Security #: | Birthdate: |
| Employed By: | |
| Home Phone #: | Work Phone #: |
| Cell Phone #: | |
| E-Mail Address: | |
| Referred By: | |

Insurance Information (If different from above)

| | |
|--|----------------------|
| Name of Insured: | |
| Relationship to Patient: | |
| Social Security #: | Birthdate: |
| Name of Employer: | |
| Home Phone #: | Work Phone #: |
| Insurance Company: | |
| Address to Mail Claims: | |
| Group #: | ID #: |
| Do you have other Dental Insurance Coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> | |

Our office will file your dental claims once. It will be your responsibility to check on your claims and do any follow up work with your insurance company. We will wait a maximum of 60 days for the insurance payment. If you wish to have our office accept your insurance and you will pay your co-payment at the time of service, we need your signature on file to automatically debit your credit card on the 61st day. If a credit card is not available, payment is due when services are rendered.

If you do not have Dental Insurance, payment is due at time of service.

| | |
|-----------------------|-----------------|
| Credit Card #: | Expires: |
| Signature: | |

Do you have or have you ever had any of the following:

| | YES | NO | | YES | NO |
|-----------------------|-----|----|-----------------------|-----|----|
| Diabetes | | | Rheumatic Fever | | |
| Heart Attack | | | Kidney Disease | | |
| Cardiac Pacemaker | | | Heart Murmur | | |
| Joint Replacement | | | Angina | | |
| Mitral Valve Prolapse | | | Hemophilia | | |
| High Blood Pressure | | | Hepatitis | | |
| Implant | | | AIDS or HIV infection | | |

Are you allergic to anything?

If so, what? _____

Please list all medications, if applicable: _____

Have you been advised to take medication prior to Dental Treatment?

If so, what? _____ Why? _____

Other physical conditions we should know about: _____

I certify that I have read and understand the preceding information to the best of my knowledge. All questions have been accurately answered. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child, to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _____

| Date | Services Rendered | Charge | Payment |
|------|-------------------|--------|---------|
| | | | |
| | | | |
| | | | |

Robert C. Phillips, Jr., DDS, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

• You May Refuse to Sign This Acknowledgement •

I, _____, have received a copy
of this office's Notice of Privacy Practice.

Name

Signature

Date

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:

| | |
|--------------------------|--|
| <input type="checkbox"/> | Individual refused to sign |
| <input type="checkbox"/> | Communications barriers prohibited obtaining the acknowledgement |
| <input type="checkbox"/> | An emergency situation prevented us from obtaining acknowledgement |
| <input type="checkbox"/> | Other (please specify) |

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 in this Notice while it is in effect. This Notice takes effect 04/14/2003 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

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 obtain payment for services we provide providing treatment to you.

Payment: We may use or 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 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 nay reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients 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 inference of you 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 Service: We will not use your health information for marketing communication 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 appropriate authorities if we reasonable 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 voice-mail 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 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 \$0.25 for each page. \$25.00 per hour for staff time to locate and copy your health information, and postage if you want 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.

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 Office: Angela Fraser
Telephone: (704)889-7525
Address: P.O. Box 686, 526 Main Street, Pineville, NC 28134