

Dental Practice Policies

Dear Patient:

Welcome to our dental office. We appreciate the opportunity to assist you with your dental care needs. Our goal is to provide you and your family with the best dental care available at an affordable cost and in an efficient and professional manner. We can only accomplish this goal with your help. With this in mind, we have listed our office policies below for your review.

_____ **Should you be unable to make your scheduled appointment we request that you notify the office at least 24 hours in advance.** We will make every effort to confirm your appointment with you; however, it is your responsibility to keep that appointment. A broken appointment fee of **\$45.00 Monday-Friday and \$75.00 for Saturday** may be billed to your account if you fail to notify the office within the time frame specified.

_____ Payment is due at the time of service. We accept cash, money orders, debit cards and all major credit cards as payment. For your convenience, we accept most dental insurances. As a courtesy, we will be happy to file your dental insurance claim to your insurance company on your behalf. **Insurance claims that are not paid within (60) days become the sole responsibility of the patient. If the balance on your account becomes more than (90) days past due, your account will be transferred to a collections agency and a fee of 30% of the balance will be added to your account.**

_____ We try very hard to adhere to a schedule. If you are more than 15 minutes late, we may have to reschedule your appointment. Sometimes an emergency will occur that will make us run behind. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing our dental family and look forward to a long relationship with you.

_____ Please understand that dentistry is **not** an exact science and therefore reputable practitioners cannot properly guarantee results. No guarantee or assurance has been made by anyone regarding dental treatment that you have requested or authorized. Each dentist is an individual practitioner and is individually and solely responsible for the dental care rendered.

_____ Your original records belong to the office. You may request copies for you or others. We will provide them within five business days upon receiving a written request from you. There will be a fee to duplicate your chart.

_____ The patient and dentist (including their corporations, representatives, staff, agents, parents, guardians, children and all related individuals and entities) agree that all litigation events that occurred in the dental office will be determined through submission to an arbitrator, and NOT by a lawsuit or other legal proceeding filed in a federal, state, county or municipal court. By signing this Arbitration Agreement, the parties waive and forfeit their constitutional, statutory or common law rights for a jury or judge to decide any legal questions or disputes, and instead accept the sole use of a private arbitrator. This Arbitration Agreement covers all disputes as to dental treatment, financial matters or any other events that occurred in dental office whether in tort (intentional or negligent), contract, statute, common law or otherwise, and including without limitation all actions relating to dental negligence, return of fees, loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. The arbitration shall bind all parties, including without limitation any spouse or heirs, and will NOT be subject to court review. Either party may initiate arbitration by serving on the other a written "Demand for Arbitration" form by certified mail. No other form of service will be acceptable. The Demand for Arbitration must identify all parties, include their contact information, describe the claims against each party, and state the amount of damages sought. Either party then may continue the proceedings by contacting the American Arbitration Association ("AAA"). A single AAA arbitrator, mutually selected by the parties, will conduct the arbitration. All proceedings will be resolved using the AAA rules. Arizona law will apply. If any provision of this Arbitration Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and effect.

Patient Signature: _____

Witness Signature: _____

Patient Print Name: _____

Witness Print Name: _____

Date: _____

Patient Information

Please Print

Title: _____ First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Patient Social Security #: _____ Patient Date of Birth: _____ Sex: **M** **F**

Email Address: _____ May we contact you by email? **Yes** **No**

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

**If patient is under the age of 18, Parent or Guardian please fill out below:*

Parent / Guardian Name: _____

Date of Birth: _____ Social Security #: _____

Insurance Information

Do you have Dental Insurance? **Yes** **No**

Primary Insurance					Secondary Insurance				
Subscriber Name: _____					Subscriber Name: _____				
Subscriber SSN: _____					Subscriber SSN: _____				
Date of Birth: _____					Date of Birth: _____				
Relationship to Subscriber:					Relationship to Subscriber:				
Self	Spouse	Child	Other		Self	Spouse	Child	Other	
Employer Name: _____					Employer Name: _____				
Employer Phone: _____					Employer Phone: _____				
Insurance Company: _____					Insurance Company: _____				
Insurance Group # _____					Insurance Group # _____				
Insurance Phone # _____					Insurance Phone # _____				
Insurance Address: _____					Insurance Address: _____				

Please present insurance card and Drivers License

AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION FORM

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

Authorization to Speak with Family/Friend (including spouses)

I give the following named person(s) authorization to take messages or speak with the office of Havasu Dentistry on my behalf regarding (please check all items authorized):

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

I understand my express consent is required to release my health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed below.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Notice of Privacy Practices



Havasu Dentistry
Lake Havasu Dentistry
1971 McCulloch Blvd N #100
Lake Havasu City, AZ 86403
(928) 733-6070
havasudentistry@gmail.com

Patient Name:
Date of Birth:
Address: , ,
Responsible Party/Guardian:
Relationship to the patient:

Date:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR RESPONSIBILITIES

We understand that medical information about you and your health is personal. Federal and state law require us to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice explaining our legal duties and privacy practices
- Follow the terms of this Notice currently in effect
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information

We reserve the right to change our privacy practices and update this Notice at any time, as permitted by law. Any changes will apply to all health information we maintain, including information created before the change.

You may request a copy of this Notice at any time.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information for the following purposes:

1. Treatment

We may use or disclose your health information to provide, coordinate, or manage your healthcare and related services.

2. Payment

We may use and disclose your health information to obtain payment for services we provide to you.

3. Healthcare Operations

We may use and disclose your health information for operational purposes, including:

- Quality assessment and improvement
- Staff training and credentialing
- Reviewing provider performance
- Licensing, certification, and accreditation activities

OTHER PERMITTED USES AND DISCLOSURES

Your Authorization

For uses not described in this Notice, we will obtain your written authorization. You may revoke that authorization in writing at any time.

To Family and Others Involved in Your Care

With your agreement, we may disclose relevant health information to family members or others involved in your care or payment for your care.

Appointment Reminders

We may contact you via voicemail, text, email, postcard, or letter to remind you of appointments.

Required by Law

We may disclose your health information when required by federal or state law.

Public Health and Safety

We may disclose information:

- To report abuse, neglect, or domestic violence
- To prevent serious threats to health or safety
- For law enforcement purposes
- For workers' compensation claims
- For health oversight activities

Legal Proceedings

We may disclose information in response to court orders, subpoenas, or administrative proceedings.

National Security and Military

We may disclose information for authorized national security or military purposes.

Organ and Tissue Donation

We may share health information with organ procurement organizations.

Coroners and Funeral Directors

We may disclose health information after death as necessary.

SUBSTANCE USE DISORDER (SUD) RECORDS

We will not use or disclose substance use disorder treatment records without your written consent, except as permitted by law.

This includes civil, criminal, administrative, or legislative proceedings unless ordered by a court after you have been notified and given an opportunity to be heard.

We will notify you of any data breach involving your SUD records in accordance with HIPAA requirements.

MARKETING AND FUNDRAISING

We will not use your health information for marketing purposes without your written permission.

You have the right to opt out of any fundraising communications.

YOUR RIGHTS

You have the right to:

Access

Inspect and obtain copies of your health information.

Request an Amendment

Request corrections to your health information if you believe it is incorrect or incomplete.

Request Restrictions

Ask us to limit how we use or disclose your health information. We are not required to agree, but if we do, we will honor that agreement except in emergencies.

Request Confidential Communications

Request that we communicate with you in a specific way or at a specific location.

Receive an Accounting of Disclosures

Receive a list of certain disclosures made in the past six (6) years, excluding treatment, payment, and healthcare operations.

Receive a Paper Copy of This Notice

Even if you receive it electronically.

Records Transfer

If our practice is sold or merged, your records may transfer to the new owner. You may request copies be sent to another provider.

QUESTIONS OR COMPLAINTS

If you have questions about this Notice or believe your privacy rights have been violated,

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

1-877-696-6775

www.hhs.gov/ocr/privacy/hipaa/complaints

We will not retaliate against you for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT

Read and approved with initials below. I, , acknowledge that I have received a copy of this Notice of Privacy Practices.

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes No DK				Yes No DK				
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes No DK				Yes No DK				
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.											
			Yes No DK				Yes No DK				Yes No DK
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Yes No DK				Yes No DK				Yes No DK
Cardiovascular disease.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of physician or dentist making recommendation:						Phone:					
Do you have any disease, condition, or problem not listed above that you think I should know about?											
Please explain:											

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

