

IMPORTANT FACTS REGARDING YOUR INSURANCE

We strongly feel our patients deserve the best possible dental care we can provide. In an effort to maintain this high quality care, we would like to share with you some facts about dental insurance.

FACT # 1

Dental insurance is meant to be an aid to help restore your mouth to sound dental health. It has been the experience of many dentists that patients have gotten the impression their insurance plan will pay up to 80%, even 100%, of their dental fees. In spite of what you are told by your insurance company, we've found many plans cover between 40-50% of an average fee. For the same procedure, some plans pay more - some pay less. The amount your plan pays is determined by how much your employer paid for the insurance plan. The less paid for insurance, the less you will receive in benefits. The more paid, the better benefits you will receive.

FACT # 2

It has been the experience of many dentists that companies sometimes tell their clients certain dental fees are "above the usual and customary fee" rather than tell them that the insurance benefits are *too low*.

We know that some companies do not update fee schedules regularly, even with the cost of living index. Remember, since the insurance company must make a profit, you can only get back in benefits what your employer puts in, less the profit the insurance company wants to make.

FACT # 3

Please read your policy so you are fully aware of any limitations of the benefits provided. Insurance carriers do NOT cover many routine dental services. In fact, some preventive procedures are not covered at all.

FACT # 4

Coinurance payments are due **at the time of treatment**. Insurance is submitted after each visit, however, the patient is responsible for the total fee and will be expected to make up for any deficiencies in the insurance coverage.

Scott Nagy, DDS, Ltd.

I have received a copy of "IMPORTANT FACTS REGARDING DENTAL INSURANCE" and I am aware that it is my responsibility for knowing the terms of my insurance coverage. Including, but not limited to, knowing my in-network and out-of-network coverage, deductibles, x-ray coverage, maximum annual benefit and co-insurance payments.

I further understand that Dr. Nagy's office will estimate my benefits based on the information given by me and by my insurance provider, but that coverage or payment is not guaranteed.

Signature

Date

I am aware that I may be charged a cancellation fee if I do not give Dr. Nagy's office at least two working days notice before cancelling an appointment.

Signature

Date

I am aware that I will be responsible for any balances not paid by my insurance provider after 60 days.

Signature

Date

If you have any questions, please ask BEFORE you start treatment. A copy of this form can be made for you at your request.

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 4/14/2003, 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 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 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 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 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 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 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 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 voicemail 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 a 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 \$25 for staff time to locate and copy your health information, and postage if you want the 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 circumstance.

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 Officer: Sheona Terry

Phone 440-322-3838

Address: 406 Ohio St. Elyria, Ohio 44035

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Scott Nagy, D.D.S., Ltd.

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 Practices.

{Please Print 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:

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

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

WELCOME

one

ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: _____
CITY STATE ZIP

Home Phone #: (____) _____

Work Phone #: (____) _____ Ext: ____

Cell Phone #: (____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? ____

Employer's Address: _____
CITY STATE ZIP

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? ____

three

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment method: ☐ Cash ☐ Check

☐ Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

two

INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: (____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: (____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Person Not Living With You ↓

four

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (____) _____

Work Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____

PLEASE CONTINUE ON BACK

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five

6
six

DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How Long? _____

Please indicate ☒ any of the following problems:

- ☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth
☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth

☐ Other: _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____ (_____) _____
Name Phone#

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain killers (including aspirin)

☐ Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin

☐ Other(s), please list: _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Heart Surg./Pacemaker | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles | <input type="checkbox"/> Xray or Cobalt Treatment |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> HIV+/AIDS/ARC | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Stomach Problems/Ulcers | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis TB | <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Jaw Problems TMJ/TMD | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma |

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin

☐ Dental Anesthetics ☐ Others: _____

Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken the drug Phen-fen and or Redux? ☐ Yes ☐ No

For women: Are you taking Birth Control pills? ☐ Yes ☐ No How many children have you had? _____

Are you Pregnant? ☐ No ☐ Yes/How long? _____ Are you nursing? ☐ Yes ☐ No

■ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

■ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

UPDATE
(OFFICE USE)

Initials _____ Date ____/____/____

Comments _____

Initials _____ Date ____/____/____

Comments _____

Initials _____ Date ____/____/____

Comments _____