PINNACLE
PERIODONTICS & DENTAL IMPLANT CENTER

Matthew D. Carlisle, DDS, MS | Marny L. Lemons-Prince, DDS

Patient Name: Today's Date_____

Last_____ **First**_____ Initial_____

Date of Birth_____ **Social Security #**_____

Married_____ Single_____ Widowed_____ Separated_____ Divorced____ Minor_____

Mailing Address:

_____ City _____ Zip ____

Home Phone_____ **Cell Phone**_____

Employer_____ Business Phone_____

Spouse_____ Spouse's Date of Birth_____

Spouse's Employer if Guarantor_____ Spouse's Social Security #_____

Person to call in case of emergency_____

Relationship _____ Phone _____

General Dentist/Referring Dentist_____

Pharmacy Name _____ Phone_____

Pharmacy Address _____

Name of Dental Insurance Company_____

Policy ID #_____ Group #_____

Group Name_____ Customer Service Number _____

Address of Insurance Company_____

Policy Holder_____ Policy Holder Date of Birth_____

Relationship to Policy Holder_____ Policy Holder Social Security #_____

Secondary Dental Insurance Company:

Name of Insurance Company_____

Group Name_____ Customer Service Number _____

Policy ID #_____ Group #_____

Address of Insurance Company_____

Policy Holder_____ Policy Holder Date of Birth_____

Relationship to Policy Holder_____ Policy Holder Social Security #_____

***Release: I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance might pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts*.** **I agree to be responsible for payment of services not paid, in whole or part by my dental insurance. In case of no dental insurance, I agree to be responsible for payment of all services.**

Signature_____ **Date**_____

See Pages Behind

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PLEASE READ CAREFULLY, SIGN, AND DATE AS DIRECTED

Our goal is to save as many of your natural teeth as possible. Our desire is to treat you in a way that is effective, comfortable, and affordable. Payment for service is due at the time services are rendered unless payment arrangements have been approved in advance.

Regarding Dental Insurance Coverage:
Not all dental services are a covered benefit in all contracts. Some insurance companies select certain services they will **not** cover. We will contact your insurance by phone for an **estimation** of benefits. There are many internal insurance guidelines that prevent estimating "**actual**" payment until your insurance claim is **processed**. That is why this is just an **ESTIMATION**!
Each insurance company offers different coverage plans. Deductibles, maximum benefits per year, and fee schedules all vary per plan because of these insurance options. If we accept assignment/disbursement from your dental insurance, any **remaining balance** is the **responsibility** of the **PATIENT/GUARANTOR**.

INSURANCE RELEASE:
I authorize release of any information concerning my (or my child's) health care and treatment for the purpose of evaluation and administering claims for insurance benefits.
I hereby authorize payment of insurance benefits directly to the Dentist or Dental Group otherwise payable to me.
I am aware that **no insurance company attempts to cover all dental costs** and that the agreement of the Insurance Company to pay for my dental care is a contract **between me and the Insurance Company**.
I understand that this office will file my insurance for me, and that my insurance benefits can only be **ESTIMATED**. If my Insurance Company does not respond to the submitted claim within 60 days, **I understand that I become responsible for the balance in full (all estimated insurance payments as well as my estimated amount due).**

Signature (patient/guardian) _____Date_____

FEES AND PAYMENTS:
I agree to be responsible for payment of this account. All balances are due in full on date of service(s).
All accounts 61 days old will be billed a finance charge in accordance with Arkansas law. Any account that payment has not been received within 60 days will be considered for collection by an outside agency.
We accept Cash, Check, Visa, MasterCard, Discover, and Care Credit (information available on request).

Signature (patient/guardian) _____Date_____

CANCELLATION POLICY:
Unless a medical condition is listed that may prevent you from giving us the appropriate notice, we reserve the right to charge **$25** for **any missed or canceled appointments without a 24-hour notice**.
Additionally, if you are scheduled for a **surgical** appointment, a **$100 an hour fee** will be charged for missed or canceled appointments without a notice of 72 hours.

Signature (patient/guardian) _____Date_____

NOTICE OF PRIVACY PRACTICES/HIPPA
I acknowledge I have received a copy of the NOTICE of PRIVACY PRACTICES (attached to the back of this packet).

Signature_____ Date_____

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Medical Records Release Authorization Form

I _____, **authorize the release of any correspondence including medical, insurance, and account information, to the following**.

_____ _____
Name/Relationship Date

_____ _____
Name/Relationship Date

_____ _____
Name/Relationship Date

I authorize the REMOVAL of any correspondence including medical, insurance, and account information, to the following:

_____ _____
Name/Relationship Date

_____
Print Patient Name

_____ _____
Signature Date

PINNACLE PERIODONTICS MEDICAL HISTORY UPDATE: COMPLETED BY PATIENT:

Patient *NAME*: **Mailing ADDRESS:**

Contact Phone *NUMBER*:

General Questions – Circle:

Are you under a physician specialist's care now for treatment? No If yes, list _____

Have you ever been hospitalized or had a major operation? No If yes, list _____

_____

Have you ever had a serious head or neck injury? Yes No If yes, which:_____

Have you ever taken Fossmax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

If yes:_____

Do you use tobacco? Yes No If yes, type/how often: _____

Do you consume alcohol? Yes No If yes, how often: _____

FOR MEDICAL ACCURACY: PLEASE LIST *ANY* MEDICATIONS TAKEN DAILY:

PREFERRED PHARMACY

NAME:

Phone Number:

Address:

WOMEN: ARE YOU… Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐

Are you *ALLERGIC* to any of the following?

Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐

Local Anesthetics ☐ Other? ☐ If yes:_____

CURRENT HEALTH **Circle ALL that apply:**

High Blood Pressure	AIDS/HIV	Heart Disease	Asthma
Low Blood Pressure	Hepatitis A	Heart Murmurs	Thyroid Disease
Any other blood disorder	Hepatitis B	Rheumatic Fever	Glaucoma
Bled excessively after cuts/injury	Hepatitis C	Liver Problems	Anemia
Diabetic	Cancer/Leukemia	Kidney Problems	Tuberculosis
Epilepsy or Seizures	Radiation/Chemo Treatment	Stomach Problems	Osteoporosis
Fibromyalgia	Mitral Valve Prolapse	Psychiatric Treatment	

Any other health conditions not previously listed above, please list here:

To the best of my knowledge, the questions on this form have been accurately answered***. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.***

Signature of Patient, Parent, Guardian:

X_____ Date:_____

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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 carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by 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 August 15, 2012, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may 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. We will post a copy of our notice in our office and on our website **www.arpinnacleperio.com** . The effective date of the Notice is provided above.

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 the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may 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 another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

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, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: s explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. 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 uses or disclosures already made with your authorization while it was in effect.

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PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: 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, and 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 fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 1225 Breckenridge Drive, Suite 210, Little Rock, AR 72205.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 1225 Breckenridge Drive, Suite 210, Little Rock, AR 72205. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 1225 Breckenridge Drive, Suite 210, Little Rock, AR.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 1225 Breckenridge Drive, Suite 210, Little Rock, AR 72205. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

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, 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 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.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
1225 Breckenridge Drive
Suite 210
Little Rock, AR 72205
501.225.4644