NEVILLS FAMILY DENTISTRY PC

David E. Nevills, DMD
Megan L. Nevills, DMD

PATIENT INFORMATION

Patient _____ Sex: Male ____ Female ____
Last First Middle Initial

Address _____
Street City State Zip

Email _____

Home phone (_____) _____-_____ Work phone (_____) _____-_____ Cell phone (_____) _____-_____

Name of Spouse/Parent/Guardian (circle one) _____

Patient's Birthdate _____/_____/_____ (mo/day/year) Patient's Social Security No. _____-_____-_____

Emergency Contact _____ Relationship _____ Phone (_____) _____-_____

Previous Dentist _____ Last Treated _____ (mo/year)

Referred by _____ Reason for visit _____

BILLING INFORMATION

Person Responsible for Payment _____ DOB ___/___/_____ SSN _____-____-_____

Address _____
Street City State Zip

Home phone (_____) _____-_____ Work phone (_____) _____-_____ Cell phone (_____) _____-_____

DENTAL INSURANCE INFORMATION

Name of Policyholder _____ Employer _____

Policyholder's ID#_____ DOB ____/____/_____ SSN _____-_____-_____ Group # _____

Insurance Company Name _____ Phone (_____) _____-_____

Mailing Address _____
Street City State Zip

SECONDARY DENTAL INSURANCE INFORMATION

Name of Policyholder _____ Employer _____

Policyholder's ID#_____ DOB ____/____/_____ SSN _____-_____-_____ Group # _____

Insurance Company Name _____ Phone (_____) _____-_____

Mailing Address _____
Street City State Zip

ASSIGNMENT AND RELEASE

I am financially responsible for services not covered by my insurance. I authorize the dentist to release my medical or dental information required to process my insurance claims. I further authorize that my insurance claims be paid to the dentist.

_____ _____

Authorizing Signature Date

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MEDICAL HISTORY

Patient's Name _____

A complete and thorough history is vital to proper care and safety. We thank you for your cooperation and patience in completing this form. All information is confidential.

PLEASE ANSWER EACH QUESTION

Primary Care Doctor: _____ City _____ Phone # _____
Date of last physical exam _____ (month) / _____ (year) General health: ☐ Good ☐ Fair ☐ Poor

	YES	NO
Have you ever been hospitalized?	☐	☐
If yes, please briefly explain _____		
Have you been treated for any illnesses within the past 12 months?	☐	☐
If yes, please briefly explain _____		
Are you now taking any prescribed medications or non-prescription drugs, including vitamins?	☐	☐
If yes, please list: _____		
Are you allergic to any drugs or medications (dental anesthetics, penicillin, codeine, aspirin, etc.)?	☐	☐
If yes, please list: _____		
Do you smoke, vape or use other tobacco products?	☐	☐
If yes, how often? _____		
Do you use marijuana? If so, how often? _____	☐	☐
Do you consume alcohol? If so, how often? _____	☐	☐
Women – are you now pregnant? If so, how far along? _____	☐	☐
Are there any inherited diseases or conditions present in your family?	☐	☐
If yes, please briefly explain _____		

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

	YES	NO		YES	NO		YES	NO
Heart attack	☐	☐	Emphysema	☐	☐	Thyroid condition	☐	☐
Circulatory problems	☐	☐	Asthma	☐	☐	Tire easily	☐	☐
Heart murmur	☐	☐	Kidney disease	☐	☐	Arthritis	☐	☐
Low blood pressure	☐	☐	Liver disease	☐	☐	Joint/valve implants	☐	☐
High blood pressure	☐	☐	Hepatitis	☐	☐	Herpes	☐	☐
Excessive bleeding	☐	☐	Jaundice	☐	☐	Frequent headaches	☐	☐
Anemia	☐	☐	Sinus problems	☐	☐	Fainting/dizziness	☐	☐
Stroke	☐	☐	Ulcers	☐	☐	Nervous disorder	☐	☐
Rheumatic fever	☐	☐	Stomach problems	☐	☐	Seizures/convulsions	☐	☐
Cancer	☐	☐	Diabetes	☐	☐	Alcohol/drug addiction	☐	☐
Tuberculosis	☐	☐	Excess thirst/urination	☐	☐	HIV/AIDS	☐	☐
Breathing difficulty	☐	☐	Glaucoma	☐	☐	Immunocompromised	☐	☐

Please add anything from your physical or mental health history that you feel is important or is not covered above:

_____

The above information is complete, and *my permission is given to discuss any portion of it with my physician*.

_____ _____

Signature of patient or parent/guardian if patient is a minor Date

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FINANCIAL POLICY

Insurance Payment of any *deductible* and your *estimated* co-pay are **expected at the time of treatment.** Please ensure we have complete and current insurance information. As a service to you, we will submit your dental insurance claims. We urge you to review and understand the benefits and limitations of your insurance policy. Please note that your dental insurance policy is a contract between you and the insurance company and it is your responsibility to pay for any balance not paid by your plan.

Usual and Customary Rates Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Please be aware that some, and perhaps all, of the services we provide may not be covered services or not considered "reasonable and customary" by your dental plan. You are responsible for payment *regardless* of any insurance company's arbitrary determination of usual and customary rates.

Visa, MasterCard, Discover Card, American Express We gladly accept Bank Card payments.

Senior Citizens (63+ years of age) We offer a 10% discount on all services for your amount due. Due to the administrative cost of processing insurance claims, this discount is not available to patients with insurance benefits.

Cash Discount We offer a 7% discount on all services of $250.00 or more **when paid in full by cash or check on the day of treatment**. Due to the administrative cost of processing insurance claims, this discount is not available to patients with insurance benefits.

Payment Plans We offer several payment plans through **CareCredit** including 6 and 12 month no-interest payment plans. You can apply in our office, online, or over the phone and get immediate approval. Ask us for more information about CareCredit.

Finance Charges All accounts are subject to a minimum Finance Charge of at least 50 cents or 1.5% of the unpaid balance, which is an Annual Percentage Rate of 18%.

Missed Appointments Please help us serve you better by keeping scheduled appointments. Our policy is to charge **$65.00** for any appointment that is missed or cancelled with less than 24 hours' notice. Patients who miss or late cancel an appointment more than once may be dismissed.

Insufficient Funds A fee of **$35.00** will be charged for all checks returned due to insufficient funds.

Minor Patients Adults accompanying a minor and the parents or guardian of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by bank credit card or payment by cash or check at time of service has been verified.

I have read the Financial Policy and understand that as a patient, or legal guardian of a minor patient, I am financially responsible for all charges in accordance with the terms and conditions set forth above. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

_____ Date:_____

(Signature of Patient or Responsible Party)

_____

(Name of minor patient, if applicable)

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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 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 April 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. If we revise our privacy practices we will notify you at your next office visit 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 will usually include consultation with specialized services directly related to treatment (i.e your physician, oral surgeons, orthodontist, denturist, dental lab technician or insurance provider). Healthcare operations occasionally include quality assessment and improvement activities, computer software consultation, 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.
- **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).
- **Marketing Health-Related Services:** We will **NEVER** use your health information for marketing communications without your written authorization.

PATIENT RIGHTS

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. We are not able to provide copies in a format other than photocopies. 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 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 confidential 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 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 INFORMATON

If you want more information about our privacy practices or have questions or concerns, please contact us.

Christine Radford, Business Operations Specialist,
Nevills Family Dentistry, PC
18540 SW Vincent, Aloha, OR 97078
Telephone: 503-649-3232 Fax: 503-649-0362

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ACKNOWLEDGMENT OF RECEIPT AND CONSENT
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

A copy of our Notice of Privacy Practices accompanies this form. You encouraged to read the Notice and ask if you have any questions about these policies and procedures. You have the right to read our Notice of Privacy Practices before you decide whether to sign this form, and we encourage you to read the Notice carefully and completely before signing.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Christine Radford, Privacy Official
Address: 18540 SW Vincent, Aloha, OR 97078
Telephone: 503-649-3232 Fax: 503--649-0362

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

_____

I have received a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices.

I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as outlined in the Notice of Privacy Practices.

You May Refuse to Sign This Form

Date: _____

Patient Name: _____

If Representative, Name and Relationship: _____

Patient/Representative's Signature: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

_____
For Office Use Only:
If patient/representative refused to sign, staff should note the reason: _____
_____ Staff Initials: _____