BVL FAMILY DENTAL CENTER

100 Buenaventura Blvd
Kissimmee, FL 34744
(407) 348-6042

WELCOME TO OUR OFFICE

Please print and complete the following information
Please have your insurance card and driver's license, or valid ID ready.

Name_____ Chart# _____
Address_____ City _____ State _____ Zip_____
Home Phone # _____Work Phone # _____ Cell Phone # _____
Birth Date _____ Age _____ Sex _____ Marital Status _____
Social Security # _____ Driver's License # _____
Employer _____Occupation _____
If you are a student, name of school/ college _____
Person to contact in case of emergency _____ Phone # _____
Who may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____
Relationship _____Employer _____ Work # _____
Is this person currently a patient in our office? Yes _____ No _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____
Employer _____ Birth Date _____ Soc. Security # _____
Insurance Company _____ Policy # _____
Insurance Phone # _____ Group # _____
Do you have additional insurance? Yes _____ No_____

FINANCIAL ARRANGEMENT

For your convenience, we offer the following methods of payment, please check the option you prefer. If you have any questions please ask for assistance. Payment due in full at the time services are rendered.
Cash _____ Check _____ Credit Cards _____ Insurance _____
If you checked insurance as a method of payment, please be advised it is the patient's/ parent's responsibility to follow up on all claims with the insurance company.

I assume responsibility for all fees and charges including those which are not covered by my insurance and collection expense if I default on my account. BVL FAMILY DENTAL CENTER policy is to require payment in full at the time services are rendered.

Signature _____ Date _____
Signature of patient (or parent if minor)

I grant authority to the dentist to perform treatment and procedure including exam, any x-rays, and cleaning. I will be advised ahead of time any procedures that need to be done. The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors of omissions that I may have made in the completion of this form. I authorize and request my insurance company to pay directly to BVL FAMILY dental benefits otherwise payable to me.

Signature _____Date _____
Signature of patient (or parent if minor)

BVL FAMILY DENTAL CENTER

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section and sign/date in the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment will result in a **$50** charge for the time reserved.

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Collections fees (up to 42% of the full balance)
Legal fees for collection services

_____ _____

Signature of Patient or Guardian Date

_____

Print Name

BVL FAMILY DENTAL CENTER

Patient Consent to receive E-mail and/or Telephone Messages

_____

Please Print (Last Name) (First Name)

I agree that the practice may communicate with me electronically at the following address:

_____

E-mail Address *(please print)*

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received/read a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

HIPAA CONSENT

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☞Patient / Parent or Legal Guardian refused to sign form _____ Date_____

Signature of Office Manager

☞Other _____

BVL FAMILY DENTAL CENTER

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on the above date, 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 provide the new Notice at our practice location, and we will distribute it 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 without authorization for the purposes of treatment, payment, and healthcare operations.

> **Treatment:** We may use or disclose your health information for your treatment. For example, we may disclose your health information to a doctor 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. For example, 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, and certification, licensing or credentialing activities

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of 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 absence or incapacity or in 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.

Marketing or Sale: We will not use your health information for marketing communications, nor disclose your health information in exchange for remuneration, without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative

proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 the protected health information of an inmate or patient under certain circumstances.

Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters), correspondence, and missed appointment notification.

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. 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 and Breach Notification: 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 5 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. Affected patients have a right to be notified following a breach of unsecured protected health information.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact BVL Family Dental Center 100 Buenaventura Blvd Kissimmee FL. 34744 407-348-6042 .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.

BVL FAMILY DENTAL CENTER
Payment Policy

Thank you for choosing BVL Family Dental Center as your Primary Dental Care provider. We are committed to providing you with quality care.

Patient Name_____ Date_____

You will be considered a Self-Pay patient if one of the following applies:

- No health insurance or
- Inactive insurance coverage or
- Having an insurance plan that does not cover the services we provide

Our Emergency Visit or Limited exam is anywhere from $75-$160* and is due at the time of service.

Problem Focused Exams/Limited Exams

A Limited oral evaluation or problem focused exam is an evaluation that is limited to a specific oral health problem or complaint. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergency, trauma, acute infection, etc. These may require interpretation of information acquired through additional diagnostic procedures.

*Charges are determined based on billing practices and are dependent on a variety of factors; which include the type and nature of the visit, and other services or procedures performed during the visit. **Therefore, an additional bill for treatment may follow depending on the services rendered**. Sign in the space provided. A copy will be provided to you upon request.

I understand and agree that I am ultimately responsible for full payment of services.

Patient's signature or Guardian_____ Date _____

BVL FAMILY DENTAL CENTER

Welcome to our Office

Please take a moment to let us know how you heard about us.

Name _____

Email Address_____

Date _____

Coupon ☐

Internet ☐

Insurance ☐

Yellow Pages ☐

Other ☐ Please describe: _____

Referral ☐ By: _____

Thank you,

We look forward to serving all your needs.

BVL FAMILY DENTAL CENTER

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

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

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

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

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

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, or GUARDIAN _____ DATE _____