Green Hills Family Dental

greenhillsdental.net ghd@mossdentalgroup.net
2121 Morgantown Road • Reading, PA 19607 (610)775-4840

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact:

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Responsible Party Information (if other than patient):

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

If no insurance enter None.

Name of Insured: _____* _____* ____
Last First MI

Insured's Birth Date:* _____ **ID #:*** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Secondary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

Is there anything about the appearance of your smile that you would like to change?

How often do you floss?

How often do you brush?

Do you have/wear dentures or partials * ◯ Yes ◯ No

If yes, do you have an upper or lower and how old are they?

Had complications from past due treatment * ◯ Yes ◯ No

Had trouble getting numb * ◯ Yes ◯ No

Had any reactions to local anesthetic * ◯ Yes ◯ No

Had/have braces, orthodontic treatment * ◯ Yes ◯ No

You experience dry mouth * ◯ Yes ◯ No

teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth * ◯ Yes ◯ No

Food gets trapped between any teeth * ◯ Yes ◯ No

Have you ever whitened or bleached your teeth * ◯ Yes ◯ No

you experienced popping and/or clicking of your jaw joint and or Jaw pain * ◯ Yes ◯ No

You have difficulty chewing * ◯ Yes ◯ No

You clench or grind your teeth * ◯ Yes ◯ No

Lip or cheek biting * ◯ Yes ◯ No

Blisters on lips or mouth * ◯ Yes ◯ No

Mouth pain during brushing * ◯ Yes ◯ No

Pain around ear * ◯ Yes ◯ No

You wear or have worn a bite appliance * ◯ Yes ◯ No

Gums bleed when brushing or flossing * ◯ Yes ◯ No

Treated for gum disease or were told you have lost bone around your teeth * ◯ Yes ◯ No

Noticed an unpleasant taste or odor in your mouth * ◯ Yes ◯ No

Experienced gum recession * ◯ Yes ◯ No

Had any teeth become loose on their own (without injury) * ◯ Yes ◯ No

Experienced a burning sensation in your mouth * ◯ Yes ◯ No

You snore or wake up frequently during the night * ◯ Yes ◯ No

If any of the checked boxes need further explanation, please describe:

FINANCIAL POLICY

Our office is dedicated to providing our patients with the best possible care and service while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy.

NONINSURANCE: Payment is expected on the day of service.

§ No insurance? No problem! We offer a discount plan that is designed to help save you money. Ask a staff member for more details.

INSURANCES: We participate with several insurance companies. Please check with our staff to see if we participate with your plan.

§ If we DO participate with your insurance company, all services performed in our office will be submitted to them, except for non-covered services. All copays, deductibles and non-covered services are the patient's responsibility and must be paid at the time of service. Please remember that co-pays quoted are merely an estimate of my dental benefits. Insurance companies only give us a basic breakdown of benefits.

§ If we DO NOT participate with your insurance company, we will submit the bill to your insurance company. All insurance carriers have a schedule of fees from which they will pay; however, the doctor's fees may be more than what the insurance company shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient. We will always provide you with an itemized bill.
IT IS IMPORTANT FOR YOU TO UNDERSTAND THAT YOUR DENTAL INSURANCE COVERAGE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY AND YOUR DOCTOR'S BILL FOR THE SERVICES PROVIDED TO YOU IS AN AGREEMENT BETWEEN YOU AND YOUR DOCTOR.

CANCELLED/MISSED APPOINTMENTS: If you do not provide us with at least a 24-hour notice of a cancelled appointment, we reserve the right to charge you for the cancelled (or missed) appointment. After 2 missed appointments, you will be dismissed from the practice.

PAYMENTS FOR SERVICES PERFORMED: Our office accepts most major credit cards and CareCredit for your convenience, as well as cash or check. Any outstanding balance is due within 30 days unless prior arrangements have been made with the billing department. There will be a charge for the bank fee for any returned checks.

You will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance. All balances that reach 90 days past due may be sent to a collection agency or District Judge. Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for all future services.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY GREEN HILLS DENTAL, PC AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT. I HEREBY AUTHORIZE PAYMENT OF MY DENTAL BENEFITS FROM MY INSURANCE COMPANY BE PAID DIRECTLY TO: GREEN HILLS DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,

HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on March 1, 2023 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health Information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (EPHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be

disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act

(GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures· of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we are not capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit

your request in writing to our Privacy Officer. Lists, if requested, will be $0 for each page and the staff time charged will be $0 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for electronic copies may not exceed $6.50 (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting an April 14, 2003.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities. Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose ii to authorized federal officials.

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, domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided-and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHR does not include disclosure's for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is a reasonable cost-based fee to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal

guardian.) We will provide access to health information in a form I format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $0 for each page and the staff time charged will be $0 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for electronic copies may not exceed $6.60 (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law.

You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form, from our Privacy Officer. We support your right to the privacy of your information and 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. HOW TO CONTACT US:

Practice Name: Green Hills Dental Privacy Officer: Office Manager
Telephone: 610-775-4840 Fax: 610-775-5468

Email: ghd@mossdentalgroup.net

Address: 2121 Morgantown Rd Reading PA 19607

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides Information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy

Practices thoroughly before signing this acknowledgement form. If the terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

Type Name of Patient

_____

_____

Type Legal Relationship to the patient -(if required} _____

Date _____

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

Name:

_____

_____

Relationship to patient: _____

Phone: _____

Name:

_____

_____

Relationship to patient: _____

Phone: _____

Consent to email or text for appointment reminders and other healthcare communication.
If you approve, we may contact you via email and /or text messaging to remind you of an appointment or provider general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

◯ Yes ◯ No

The cell phone number I authorize to receive text messages for appointment reminders and general health information is

_____

The email address I authorize to receive email messages for appointment reminders and general health information

is

_____

_____

I decline to receive communications via text ◯ Yes ◯ No

I decline to receive communications via email ◯ Yes ◯ No

REVOCATION--use this area to document revocation of a previous from of communications.
I hereby revoke my request to receiver future appointment reminders or healthcare updates via text ◯ Yes ◯ No

I hereby revoke my request to receive future appointment reminders or healthcare updates via email ◯ Yes ◯ No

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Response Date: _____