Authorization for Release of Information

Name of Patient:_____ **Date of Birth**:_____

Anderson Dental Group is authorized to release protected health information about the above-named patient in following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each box that can be released to the person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication (provide email address below) * _____ *For email communication to occur, please accept the disclosure below.	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication (provide number below) * _____ *For text communication to occur, accept the disclosure below.	☐ Appointment reminder ☐ Other: _____

☐ For **email and/or text communication:** I understand that if information is not sent in an encrypted manner that there is a risk it could be accessed illegally. I still elect to receive email and/or text communication as selected above.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____

Signature of Patient or Personal Representative **Date**

This authorization will remain in effect until revoked by the patient
*Description of Personal Representative's Authority (attach necessary documentation)

Acknowledgement of Receipt of Notice of Privacy Practices

For Anderson Dental Group

I hereby understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received, read, and understood a copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the following address—attention Privacy Officer—to obtain a current copy of the Notice.

I understand that I may request in writing that Anderson Dental Group restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand ADG is not required to agree to my requested restrictions; however, if agreed upon, ADG is bound to abide by such restrictions.

Privacy Officer
1819 E Innes St., Suite 2
Salisbury, NC 28146
704-636-3611

Patient/Responsible Party Signature:_____ **Date:**_____

Office Use Only:

____ I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Office Signature:_____ Date:_____

ANDERSON DENTAL GROUP

Name: _____

Mailing Address: _____

_____

Phone: _____

Consent

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient's name)_____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment **mutually agreed upon by me** and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication or therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. I agree to be responsible for and understand that I am responsible for payment of all services rendered on my behalf or my dependents. I understand that I am responsible for whatever my insurance company does not pay and that payment is due at the time of service unless other arrangements have been made. In the event payments are not received within 60 days of date of billing, I understand that a month 1 1/2% finance charge (18% APR) will be added to my account.

I authorize the rendering of diagnostic and treatment procedures, including local anesthesia, by Drs. Jimmie & Luanne Anderson, which in their professional judgment may be deemed necessary or beneficial.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Treatment	
__x___	Implants
__x___	Crowns/Bridges/Veneers
__x___	Composites/Amalgams
__x___	Root Canal Therapy
__x___	Extractions
__x___	Sealants
__x___	Dentures/Partials
__x___	Bite Splint/Guard
__x___	Whitening
__x___	Anesthetic

Treatment	
__x__	Exams
__x__	Prophylaxis (cleaning)
__x__	X-Rays
__x__	Fluoride
__x__	Perio Maintenance
__x__	Scaling and Root Planing

I understand that dental disease will progress without treatment. I understand that should I refuse recommended treatment or diagnostic treatment including radiographs the doctors are not responsible for disease progression. Treatment recommendations are based on most recent exam and diagnostic materials.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Payment Policy

Please be aware that you are legally responsible for the payment of all charges. We operate on a fee-for-service basis and therefore payment is required at each appointment. We accept Cash, Check, Visa, Mastercard, and Discover, American Express and Care Credit. For our patients with insurance, we will file your primary claims for you as a courtesy; however, we do expect your portion at the time of treatment. If we do not receive payment from your insurance company within 60 days from the date of service, you will be expected to pay for all dental services in full. All balances over 90 days are subject to a 1.5% service charge. In the event your account becomes past due, you will be responsible for any recovery fees.

Please remember that any insurance policy is a contract solely between you as a patient and the carrier of your insurance. Please make yourself aware of the benefits of your specific policy. Fees are valid for 30 days only

Appointment Policy

We do see all patients by appointment only. If you are unable to keep a scheduled appointment, we ask for a minimum of fourty-eight (48) hours notice. If the office is closed when you call, please leave a message with our answering service.

In consideration of our patients that are waiting to be scheduled, it has become necessary to charge for multiple broken appointments. A minimum fee of $50.00 per half hour may be charged.

Patient/Responsible Party Signature_____

Anderson Dental Group - Medical History

Patient Name: Birth Date:

Emergency Contact/POA or Legal Guardian/ Driver: List Name and Phone Number

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, chemotherapy?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Do you use tobacco?	Yes No	If yes	
Do you use controlled substances?	Yes No	If yes	

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease/Dementia	Yes No	Diabetes	Yes No	Hepatitis A, B or C	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Renal Dialysis	Yes No	Anemia	Yes No
Easily Winded	Yes No	Parkinsons	Yes No	Rheumatic Fever	Yes No	Emphysema	Yes No
High Blood Pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No
High Cholesterol	Yes No	Scarlet Fever	Yes No	Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No
Hives or Rash	Yes No	Shingles	Yes No	Artificial Joint Replacement (Hip, Knee)	Yes No	Excessive Thirst	Yes No
Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No	Fainting Spells/Dizziness	Yes No
Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No	Frequent Cough	Yes No
Kidney Problems	Yes No	ADHD, ADD	Yes No	Blood Transfusion	Yes No	Frequent Diarrhea	Yes No
Leukemia	Yes No	Stomach/Intestinal Disease	Yes No	Breathing Problems or COPD	Yes No	Frequent Headaches	Yes No
Liver Disease	Yes No	Stroke	Yes No	Bruise Easily	Yes No	Anxiety or Depression	Yes No
Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer +/or Chemotherapy	Yes No	Glaucoma	Yes No
Lung Disease	Yes No	Thyroid Disease	Yes No	Austism	Yes No	Hay Fever	Yes No
Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No	Chest Pains	Yes No	Heart Attack/Failure	Yes No
Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No
Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No
Ulcers	Yes No	Acid Reflux/ Frequent Vomiting	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No
Venereal Disease, STD, Genital Herpes	Yes No	Yellow Jaundice	Yes No	CPAP	Yes No	Face or Jaw Pain	Yes No
Hearing Loss/Hearing Aide	Yes No	Ortho/Braces/Invisalign	Yes No	Bite guard/Bite Splint/Night Guard	Yes No	Pregnant/Nursing	Yes No
Taking Oral Contraceptives	Yes No	Sjogren's Syndrome	Yes No				

Have you ever had any serious illness not listed above? Yes No If yes

Add'l 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:

X Date:_____