North Grove DENTAL
Perfecting Smile After Smile
Dr. Mark Beard

Welcome to North Grove Dental! We're glad that you're here and feel honored that you've chosen us to provide you with quality dentistry. As an office that honors excellence and integrity, we believe that it is our responsibility to be informative, honest and forthright. The following agreement is indicative of our respect for your right to know our protocol and policies. You will receive these forms back for your records once scanned into our database. We gladly welcome any questions you may have!

Office Policies

Confirming Your Reserved Appointment: Our by-appointment only schedule books heavily in advance because of our belief in quality care. Confirming whether or not you will be attending an appointment reserved for you based on your specific treatment is important. We will text or call you (your preference) one week before your scheduled appointment. Please confirm via text or voicemail (you may leave a voicemail after hours) whether or not you will be attending the appointment. Once confirmed, we will text or call you with a friendly reminder the day before**. If the appointment is not confirmed within 24 business hours, then the appointment will be cancelled to accommodate others needing our care.** If you are late to an appointment, notifying us is an appreciated courtesy so that we may properly accommodate the patient following your appointment. We regret that we cannot continue to accommodate those who repeatedly fail or cancel appointments. **Thank you for your respect of our time and other patient's time.**

Please provide ****at least two****daytime phone numbers at which you may be reached and an email address:

Home Phone:_____ Cell:_____ Work:_____

Other: (please specify):_____ Email Address:_____

Filing Your Dental Insurance Benefits: We are committed to ensuring that your insurance will be compliantly used to your financial benefit. However, please understand that North Grove Dental files your insurance as a courtesy service since your insurance policy is a contract between you and your insurance company. Though we verify your benefits with your insurance company on your behalf, we can only estimate your coverage based on what they tell us about your policy. Prior to any basic or major treatment, we will give you an in-office estimate based on what we know about your coverage for treatment that will also be submitted to the insurance company for approval which will better determine your out-of-pocket expense due on the day of the appointment**. If you have an in-network/PPO policy, then your insurance company – not North Grove Dental – will make the final determination on the cost of treatment at a discounted rate. Otherwise, all fees are "reasonable and customary." By asking North Grove Dental to file insurance on your behalf, you are in agreement to paying the full amount regardless of what insurance agrees or disagrees to pay after treatment, understanding that knowledge of all benefits is your responsibility as an insurance policy holder/investor.**

Treatment, Billing & Collections: Payment for your estimated out-of-pocket expense will be due on the day of service. We gladly accept cash, personal check VIA Telecheck, VISA, and MasterCard. Checks cannot be held. Though we welcome patients to build non-refundable credits on their accounts for future treatment, financing is otherwise only offered through Care Credit, which offers 6 and 12 month no interest payment plans in the amounts of $300 or more. Services determined by your insurance company as not being covered by your policy after treatment will be billed. We will send you a maximum of three statements over a 60 day period. We cannot be responsible for a change of address without notice. If the bill is not paid within 60 days, a 30% increase will be added to the balance and the account will be submitted to a collections agency. All future appointments will be cancelled and cannot be rescheduled until the balance is paid. Once submitted, the balance can only be paid to the collections agency. Please notify us when temporary financial issues may affect the timely payment of your balance so that we may assist you with managing your account.

Minor Patients & Dependents Who Drive: Minors (4-15) must be accompanied by a guardian/parent to their appointment. We welcome encouraging parents of young children to be present in treatment area as we truly wish for children to have a positive experience. Dependents who drive will be texted a confirmation/reminder text to their phone with their guardian in a group text. Payment may be made by the guardian VIA phone call at check out on the day of treatment or by the guardian attending the appointment.

Consent & Authorization: I, (please print) _____, authorize dental treatment and agree to pay all related professional fees. I understand that fees not covered by my dental insurance must be paid by me promptly upon notification from this office or my insurance company. I understand that North Grove Dental is a private practice that reserves the right to terminate professional treatment when deemed necessary and that my compliance with the above policies is required to receive treatment. I have read and understand this document in its entirety. Without reservation, I agree to abide by the policies outlined herein.

Patient signature:_____ Date:_____

Thank you for being here! We appreciate you and the opportunity to perfect your smile!

Medical History Form

PATIENT NAME (please print):_____ **DATE OF BIRTH:** _____

ADDRESS:_____

SOCIAL SECURITY # (if patient is a minor please list name and SS# of guardian):_____

EMERGENCY CONTACT NAME, PHONE NUMBER & RELATIONSHIP:_____

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.

Please circle "Yes" or "No" to all that apply:

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	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes, please explain: _____
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? Please place an "X" beside all that apply:

Aspirin _____ Penicillin_____ Codeine_____ Acrylic_____ Metal_____ Latex_____ Local Anesthetics_____

If you are allergic to something not listed above, please explain:_____

Do you use controlled substances? Yes No If Yes:_____

Do you have, or have you had, any of the following? Please place an "X" beside all that apply:

_____AIDS/HIV Positive	_____Cortisone Medicine	_____Hemophilia	_____Renal Dialysis
_____Alzheimer's Disease	_____Diabetes	_____Hepatitis A	_____Rheumatic Fever
_____Anaphylaxis	_____Drug Addiction	_____Hepatitis B or C	_____Rheumatism
_____Anemia	_____Easily Winded	_____Herpes	_____Scarlet Fever
_____Angina	_____Emphysema	_____High Blood Pressure	_____Shingles
_____Arthritis/Gout	_____Epilepsy or Seizures	_____Hives or Rash	_____Sickle Cell Disease
_____Artificial Heart Valve	_____Excessive Bleeding	_____Hypoglycemia	_____Sinus Trouble
_____Artificial Joint	_____Excessive Thirst	_____Irregular Heartbeat	_____Spina Bifida
_____Asthma	_____Fainting Spells/Dizziness	_____Kidney Problems	_____Stomach/Intestinal Dis.
_____Blood Disease	_____Frequent Cough	_____Leukemia	_____Stroke
_____Blood Transfusion	_____Frequent Diarrhea	_____Liver Disease	_____Swelling of Limbs
_____Breathing Problem	_____Frequent Headaches	_____Low Blood Pressure	_____Thyroid Disease
_____Bruise Easily	_____Genital Herpes	_____Lung Disease	_____Tonsillitis
_____Cancer	_____Glaucoma	_____Mitral Valve Prolapse	_____Tuberculosis
_____Chemotherapy	_____Hay Fever	_____Pain in Jaw Joints	_____Tumors or Growths
_____Chest Pains	_____Heart Attack/Failure	_____Parathyroid Disease	_____Ulcers
_____Cold Sores/Fever Blist.	_____Heart Murmur	_____Psychiatric Care	_____Venereal Disease
_____Congenital Heart Dis.	_____Heart Pace Maker	_____Radiation Trtment.	_____Yellow Jaundice
_____Convulsions	_____Heart Trouble/Disease	_____Recent Weight Loss	

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

_____

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 or PARENT/GUARDIAN: _____ **DATE:** _____

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220 North Grove Medical Park Drive – Spartanburg, SC – 29303 –(864) 585-5555

HIPAA NOTICE OF PRIVACY LAWS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:
when a state or federal law mandates that certain health information be reported for a specific purpose;
for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices; disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies; disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations; uses or disclosures for health related research;
uses and disclosures to prevent a serious threat to health or safety; uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service; disclosures of de-identified information;
disclosures relating to worker's compensation programs; disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or

disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

I acknowledge that I have been offered a copy of North Grove Dental's Notice of Privacy Practices and understand that North Grove Dental is a HIPAA compliant office.

Signature:_____ **Date:**_____