ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR LOWELL DISTRICT DENTAL, P.C.

****You May Refuse to Sign This Acknowledgement****

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

{Signature} {Date}

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Patient refused copy of Notice of Privacy Practices

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR LOWELL DISTRICT DENTAL, P.C.

SECTION A: PATIENT GIVING CONSENT

Name: _____DOB _____

Phone Numbers_____SSN _____

Address: _____

_____

_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice 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 accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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:

Contact Person: **Arnold B Cullum, DDS**
251 E Fountain Blvd Unit 100
Colorado Springs, CO 80903
Phone 719-591-2004
Fax 719-623-0305

Right to Revoke**: 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.**

CONSENT
I, (Print Name) _____ , 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 heath care operations.

Signature: _____ Date:_____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT
I, (Print Name)_____, revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.
Signature: _____ Date:_____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient:_____

Please Complete the Following Confidential Information

PATIENT INFORMATION

Whom May We Thank, For Referring You to Our Office? _____

Patient Information

Name _____ Social Security #_____

Are You? Minor Single Separated Divorced Widowed Married

Date Of Birth _____ Age _____Male/Female

Spouse's Name _____

Home Phone # _____ Cell Phone #_____Pager #_____

Work Phone # _____ Ext._____Other #'S_____

Home Address _____

_____

Mailing Address_____

_____

Occupation_____Year's At This Occupation _____

Employer _____

Employer's Address_____

_____

Guarantor's Information (Person Responsible for Account) Relation to Patient _____

Name _____Social Security # _____

Date Of Birth _____ Age _____Male/Female

Home Phone # _____ Cell Phone #_____Pager #_____

Work Phone # _____ Ext._____Other #'S_____

Home Address _____

_____

Mailing Address_____

_____

Occupation_____Year's At This Occupation _____

Employer _____

Employer's Address_____

_____

Dental Insurance Primary Carrier Secondary Carrier

Insurance Company _____

Phone Number _____

Group Number_____

Policy Number_____

Subscriber's Name / SSN_____

In Case of Emergency Contact

Name _____Relation to Patient _____

Address _____

_____

Home Phone_____ Work _____Ext. _____

I Certify That To The Best Of My Knowledge The Above Information Is Complete And Accurate.
I Promise To Notify This Office within Two Weeks of Any Changes to My Patient Information.

Signature of Patient _____Date _____

Patient Name_____ Chart_____ **MEDICAL HX**

In order to provide safe and effective dental treatment all of the following questions must be answered.

1.	Physician's Name_____ Phone_____ Address_____ Fax_____		
2.	Are you under a physician's care?_____	NO	YES
	If yes, what for?_____		
3.	When was your last complete physical?_____		
4.	Are you taking any medications or substances? _____	NO	YES
5.	Do you routinely take health related substances? _____	NO	YES
6.	Are you allergic to any medications or substances?_____	NO	YES
7.	Do you have any problems with antibiotics, anesthetics or other medications?	NO	YES
8.	Do you have any allergies?_____	NO	YES
9.	Are you sensitive to any metals or latex?_____	NO	YES
10.	Have you been treated for or told you have heart disease?_____	NO	YES
11.	Do you have a pacemaker or a heart implant?_____	NO	YES
12.	Have you ever had rheumatic fever? _____	NO	YES
13.	Do you have a heart murmur?_____	NO	YES
14.	Do you have any artificial joints or prosthesis? _____	NO	YES
15.	Do you have high or low blood pressure? _____	NO	YES
16.	Do you have arthritis, rheumatism or other inflammatory disorder? _____	NO	YES
17.	Do you have anemia, leukemia or other blood disorder? _____	NO	YES
18.	Have you ever bleed excessively after being cut or injured? _____	NO	YES
19.	Do you have any stomach or digestive problems? _____	NO	YES
20.	Do you have any kidney problems? _____	NO	YES
21.	Do you have any liver problems? _____	NO	YES
22.	Do you have high or low blood sugar levels? _____	NO	YES
23.	Are you diabetic? _____	NO	YES
24.	Do you have asthma, emphysema or tuberculosis?_____	NO	YES
25.	Do you have epilepsy or seizure disorders? _____	NO	YES
26.	Do you now or have you had a venereal disease? _____	NO	YES
27.	Have you tested positive for HIV? _____	NO	YES
28.	Have you tested positive for hepatitis? _____	NO	YES
29.	Have you had psychological or psychiatric treatment? _____	NO	YES
30.	Do you use tobacco products? _____	NO	YES
	If yes, which type and how often. _____		
31.	Do you consume alcoholic beverages? _____	NO	YES
	If yes, how often? If no, why? _____		
32.	Do you use illicit drugs? _____	NO	YES
	If yes, which type and how often. _____		
33.	Do you have any disease, condition or problem not discussed above? _____	NO	YES
	If yes, please explain. _____		
34.	Is there anything else we should know about your health? _____	NO	YES
	If yes, please explain. _____		
35.	For women, are you pregnant or suspect you may be? _____	NO	YES
	If yes, what trimester or month are you in today? _____		
36.	Are you using birth control medications?_____	NO	YES

I certify that to the best of my knowledge, the above information is complete and accurate.
I promise to notify this office immediately if there is a change in my health history.

Patient or Guardian Signature_____ Date _____

Doctor's Signature_____ Date _____

Patient Name_____ Chart_____ **DENTAL HX**

In order to provide safe and effective dental treatment all of the following questions must be answered.

1. Previous dentist name_____ Phone_____
   Address_____ Fax_____
   _____
2. Reason for today's visit?_____
3. When was your last dental visit and what did you have done?_____
4. Date and type of last dental radiographs (X-rays)?_____
5. When were your teeth last cleaned?_____
6. Do you brush your teeth?_____ NO YES
   If yes, how often?_____
   If yes, bristle strength is: soft medium hard
7. Do you floss?_____ NO YES
   If yes, unwaxed waxed tape periodontal or superfloss
8. Do you use mouth rinse?_____ NO YES
   If yes, what type?_____
9. Have you had teeth removed (pulled)?_____ NO YES
10. Were these teeth replaced?_____ NO YES
11. Do you wear complete dentures, partial dentures or fixed crowns or bridges? NO YES
    If yes, how old are they?_____
    If yes, are you pleased with them?_____
    If no, are you aware of dental implant successes?_____
12. Have you had periodontal treatment?_____ NO YES
    If yes, by which dentist and when?_____
13. Have you had a root canal?_____ NO YES
    If yes, by which dentist and when?_____
14. Have you had orthodontic (braces) treatment?_____ NO YES
    If yes, by which dentist and when?_____
15. Do you have sensitive teeth?_____ NO YES
    If yes, which ones?_____
    If yes, circle all that apply, Hot Cold Pressure (chewing) Sweets.
16. Are any of your teeth shifting or loose?_____ NO YES
17. Do your gums bleed or hurt?_____ NO YES
18. Do you have an unpleasant taste in your mouth?_____ NO YES
19. Do you feel you have bad breath?_____ NO YES
20. Does food wedge between your teeth?_____ NO YES
21. Do you wake up tired in the morning?_____ NO YES
22. Does your bed partner feel you snore?_____ NO YES
23. Does your jaw pop or click?_____ NO YES
24. Do you have pain in your ears or jaw joint?_____ NO YES
25. Do you have pain in your jaw when opening wide or moving to right or left? NO YES
26. Are you aware of clenching or grinding your teeth?_____ NO YES
27. How do you feel about your teeth?_____
28. Are you unhappy with the way your teeth look?_____ NO YES
29. Do you have difficulty eating the foods you want?_____ NO YES
30. Have you had an unpleasant dental experience?_____ NO YES
31. Have you ever had complications or illness following dental treatment? NO YES
32. Is there anything else that we should know about your dental history? NO YES
    If yes, please explain._____

I certify that to the best of my knowledge the above information is complete and accurate.
I promise to notify this office as soon as possible if there is a change in my dental history.

Patient or Guardian Signature_____ Date_____

Doctors Signature_____ Date_____

Date_____

FINANCIAL AGREEMENT

Chart _____ Patient Name _____

Thank you for choosing us as your dental health care provider. We are committed to providing you with the finest quality dental services, that are consistent with your wants and needs. In order to provide safe, effective and informed dental treatment, proper information must be provided to you and your consent must be obtained.

Financial Responsibility Agreement (you consent and agree to the following)

1. **You agree that your estimated portion payment is due at the time services are rendered. We accept cash, check, credit card payments and the "health care credit line". Payment options are made available on an individual basis.**

2. You agree to be responsible for payment of all services rendered on your behalf or the person you are guarantor for.

3. As a courtesy to our patients we will process your insurance forms. Insurance coverage whether under a major medical or dental policy is a contract between the patient (and patient's employer) and the insurance company. It is **not** an agreement between our office and your insurance company. Lowell District Dental, P.C. has an agreement with you, the patient. Your insurance company has an agreement with you (or your employer) and your **benefits** are based on this agreement. We will work with you to maximize your insurance benefits; however you are responsible for payment to Lowell District Dental, P.C.

4. You understand that your dental insurance company **may** pay less for a procedure (based on your benefits agreement) than we bill and that you will be responsible for the full balance on your account. How much reimbursement and under what terms your insurance company pays for a procedure is based on your benefits agreement. You should have a copy of this agreement.

5. If you cancel your appointment 24 hours prior to the scheduled appointment time, no charge will be made to your account.

6. Failure to give 24 hours notice for cancellation or not showing for your scheduled appointment time will result in a charge of $75.00 per hour of appointment time scheduled for you.

7. Statements will be mailed at your request, but for each statement mailed we will add a service charge of $4.00 per statement mailed.

8. After insurance payment or decline, finance charges will be calculated on the last day of each month for balances over 30 days. The finance charge will be a periodic rate of 1.5% per month (18% APR).

9. Payment balances over 60 days will be considered in default. If you default on payment, you agree to pay the full balance due immediately (including interest and service charges). You also agree to pay for any and all collection costs and attorney fee's incurred to settle your defaulted balance.

10. Authorization to pay benefits directly to dentist. I hereby authorize payment To Lowell District Dental, P.C. of the dental benefits otherwise payable to me.

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Date_____

TREATMENT AGREEMENT

Chart _____ Patient Name _____

Thank you for choosing us as your dental health care provider. We are committed to providing you with the finest quality dental services, that are consistent with your wants and needs. In order to provide safe, effective and informed dental treatment, proper information must be provided to you and your consent must be obtained.

Treatment Consent Agreement (you consent and agree to the following)

1. I hereby authorize the dentist or designated staff to review my medical and dental records and I consent to a head, neck, oral examination and any other examination that is deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.

2. I hereby authorize the dentist or designated staff to take x-rays, photographs and any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.

3. Upon such diagnosis, I authorize the dentist or designated staff to perform all recommended treatment, **mutually agreed upon by me,** required to provide proper dental care.

4. I consent to the use of appropriate medications and therapies as deemed necessary. I consent to the use of local anesthetics and/or relaxation medications as deemed necessary. I fully understand that using these medications and therapies involve certain risks.

5. I realize that a successful outcome for my dental care requires that I follow all instructions and recommendations given by the dentist. I agree to follow these instructions and recommendations and accept responsibility for **all** outcomes when I do not follow instructions and recommendations.

6. I consent to allow the dentist to utilize any x-rays, photographs, study models or other information related to my diagnosis and/or treatment, for educational purposes or in scientific presentations. Any material will be presented in a completely anonymous manner.

7. Authorization to release information. Lowell District Dental, P.C. is authorized to provide any insurance company(s), claim administrators and consulting health care professionals information concerning my medical and dental records for evaluation of insurance claims benefits.

8. Authorization to consult other health care providers. Lowell District Dental, P.C. is authorized to consult with other health care professionals concerning my medical and/or dental records so as to facilitate my dental and health care.

9. Dental evaluations are essential to maintain good oral health. I accept that I am responsible for my oral health. I agree that I will see the dentist at least every six-(6) months and I agree to call the dental office for an evaluation if I have not seen the dentist in six-(6) months.

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____