WELCOME!

Thank you for choosing our practice for your dental needs. Please complete this form as thoroughly as possible. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be more than happy to help.

Patient Information

(Please print)
Name_____ Birth Date_____
Social Security # _____ *Necessary for insurance purposes*

Address_____City_____State____Zip_____

Sex: ◇ Male ◇ Female

Home Phone (____)_____ Cell Phone(____)_____ Work Phone(____)_____
**Which number do you prefer we use? _____

◇ Married ◇ Widowed ◇ Divorced ◇ Single ◇ Minor ◇ Partnered for____years

Patient Employer/ School _____
Occupation _____
Spouse or parent's name_____
How were you referred to this office? _____
Emergency Contact_____Phone (_____)_____
* What Pharmacy do you use?*_____Phone:_____

Dental Insurance Information

Name of Employer _____
Name of insurance company_____
Name of policy holder_____
Relationship to patient_____
Policy Holder's Birth Date_____ ID/SS # _____

Do you have additional coverage? _____ If YES, please complete the following:

Name of Secondary insurance co._____Employer_____
Name of Policy holder_____
Policy Holder's Birth Date_____ ID/SS # _____

Dental History

Former dentist_____ Date of last exam_____ Date of last x-rays_____
Reason for today's visit_____

WHAT PHARMACY DO YOU USE?_____ NUMBER_____

Medical History

Physician_____ Date of last visit_____
Please list ALL medications you are currently taking. (If you have a list please allow us to make a copy)

_____
_____
List any allergies that you have:

_____
Have you ever had a reaction to local anesthetic? (Novocaine)

_____

Women: Are you pregnant? _____ Nursing _____ Taking birth control pills_____
Circle any conditions below that you have or have had in the past:

1. AIDS/HIV	**13.Cortisone treatments**	**25.High blood pressure**	**37.Skin Rash**
2. Anemia	**14.Cough, persistent**	**26.Jaw pain**	**38.Stroke**
3. Arthritis	**15.Diabetes**	**27.Kidney disease**	**39. Swollen ankles**
4. Artificial valves/ joints	**16. Epilepsy**	**28. Liver disease**	**40. Thyroid problems**
5. Asthma	**17. Fainting**	**29. Mitral valve prolapse**	**41. Tobacco habit**
6. Autism	**18. Glaucoma**	**30. Nervous problems**	**42. Tonsillitis**
7. Bleeding abnormally	**19. Head/Back aches**	**31. Pacemaker**	**43. Tuberculosis**
8. Blood disease	**20. Heart murmur**	**32. Psychiatric care**	**44. Ulcer**
9. Cancer	**21. Heart, other condition**	**33. Respiratory disease**	**45. Venereal disease**
10. Chemical dependency	**22. Hemophilia**	**34. Rheumatic fever**	
11. Chemotherapy	**23. Hepatitis**	**35. Scarlet fever**	
12. Circulatory problems	**24. Hernia repair**	**36. Shortness of breath**	

If you circled any of the above conditions, use this space to write the number and elaborate about your condition. For example, if you circled #9 you would write #9 below and write when you had it and what kind of treatment you received. Also use this space to document any condition not listed above.

_____
_____

Certification

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative_____ Date_____
Please print the name of the patient_____ Relationship_____

BRIAN T. WEIBLING, DDS LLC
3870 STARR'S CENTRE DRIVE
CANFIELD, OH. 44406

GENERAL CONSENT

I, _____, consent to be a patient at the above named office and agree to a full clinical examination with radiographs (radiographs may be refused, with the understanding that a thorough and accurate exam is impossible without them.) **I also understand and consent to the following:**

1. During the time period in which I choose to remain a patient in this practice, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery (extractions of teeth), endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry (fillings), temporomandibular joint (TMJ) disorder treatment, desensitizing of teeth, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist the ability to communicate with my other medical practitioners to inquire about any aspect of my health history.

3. It is impossible to 100% guarantee treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I understand much of the success of the dental treatment provided in this office is dependent on how well I personally care for it outside of this office.

4. I recognize the need for my dentist to exercise his/her professional judgment on my behalf, and I therefore authorize my dentist to select alternate methods of treatment based on my condition as disclosed during the procedure(s) authorized by my execution of this form, including conditions which were unknown at the time the surgery or dental procedure(s) were begun.

5. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if insurance pre-estimates are given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover as plan benefits are constantly changing, many times without notification being provided to this office.

6. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

7. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Signature Date

_____

Patient or Guardian Name (please print)

_____ _____

Witness Signature and initials Date

BRIAN T. WEIBLING, DDS LLC
3870 STARR'S CENTRE DRIVE
CANFIELD, OH. 44406

INSURANCE AND FINANCIAL POLICY

- We believe you deserve the best dental care possible, and we will always try to present you with the best solution to treat your personal needs. Some of our patients have dental insurance benefits; others do not. Regardless of your specific situation, here are some important things we would like you to know:

- Your dental benefits are based on a contract between you and the insurance company. If you have any questions regarding your dental benefits, please contact your EMPLOYER or INSURANCE COMPANY directly. We will do everything in our power to help you navigate what can be a confusing process, but please remember: we were not present when fees and covered/non-covered procedures within your plan were negotiated. We will process your claim as a courtesy, but we have no control over co-pay percentages, deductable amounts, or approved treatment that falls under you specific plan.

- We will recommend and perform treatment based on the standard of care and what is appropriate for your specific treatment needs. The procedure(s) we perform will be submitted to your dental insurance company for processing with the proper corresponding CDT (Code for Dental Terminology) attached. This DOES NOT, HOWEVER, guarantee insurance coverage. Again, we were not present when fees and covered services were negotiated. Although your insurance company provides us with a copy of CDTs and their associated fees, this DOES NOT guarantee they will cover your specific treatment under your specific plan.

- As previously stated, we will bill your insurance company as a courtesy. If your insurance does NOT pay within 90 days, we reserve the right to request payment in full from you for services rendered. You will then be responsible for collecting the insurance funds that are due to you. Again, please remember this is a contract between YOU and the INSURANCE COMPANY. Ultimately, you are responsible for ALL CHARGES you incur for services provided by our office.

- We currently accept all private care insurance plans that allow you to select the provider of your choice. This does NOT necessarily mean we are an in-network, participating provider for your plan. Due to the extensive number of available plans, it is impossible to know for certain what your plan will pay. We will ESTIMATE your co-pay portion based on the most current information we have, but this is ONLY AN ESTIMATE. If you would like to know exact plan amounts, please contact your insurance company directly.

- DR. WEIBLING REQUIRES ALL DEDUCTIBLES, COPAYS, UNPAID CLAIMS AND ACCOUNT BALANCES TO BE PAID IN FULL AT THE TIME OF YOUR OFFICE VISIT. We accept Visa, MasterCard, cash and checks (for existing patients with established payment history.) **We do NOT accept checks over $1000.00 for any patient.** If you do not have in-network insurance coverage and are in need of an extended financing option for your balance, we work with CARE CREDIT. The application can be completed over the phone or on-line (carecredit.com) In the event you do not qualify for Care Credit, we unfortunately cannot provide in-house financing. **Care Credit is not an available option to pay off in-network balances in this office.**

- If your account becomes greater than 90 days unpaid we will refer your account to our collection service and a processing fee of $40.00 will be charged to your account.

*****WE KINDLY ASK FOR AT LEAST 24 HOURS NOTICE FOR ANY APPOINTMENT CANCELLATIONS.*****

IN THE EVENT OF A NO SHOW, A $35.00 FEE WILL BE APPLIED TO YOUR ACCOUNT.

I understand and agree to the above conditions.

Patient/ Parent Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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. PLEASE REVIEW IT CAREFULLY.

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 10/13/2014, 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, Brian T. Weibling, DDS. 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 aren't 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 $0.10 for each page and the staff time charged will be $0.00 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.

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 on 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 it 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, or 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 PHI" does not include disclosures 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 / 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 $0.10 for each page and the staff time charged will be $0.00 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.

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: Brian T. Weibling DDS LLC Privacy Officer: Brian T. Weibling, DDS

Telephone: 330-533-1961 Fax: 330-533-2515

Address: 3870 Starr's Centre Drive Canfield, Ohio 44406

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*