SMITH
DENTAL SPECIALTIES

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

The information you provide in this packet is vital and will assist the doctor during the review of your symptoms. Please respond to all questions. Questions contained within are confidential and will become a part of your healthcare record. Some questions are intended for governmental/statistical purposes only.

PATIENT INFORMATION

Name: _____ **Sex**: F ◯ M ◯
Last First Middle Initial

_____
Home Address City State Zip Code

_____/_____/_____ _____ _____ _____
Date of Birth Height Weight Email Address

Social Security Number: _____ - _____ - _____

Marital Status: Married ◯ Single ◯ Separated ◯ Divorced ◯ Widowed ◯ # of Children ____

Education: _____ **Employment:** _____

Patient Occupation: _____ Business Phone #: _____

PATIENT TELEPHONE NUMBERS

Primary Number: _____ Home ◯ Work ◯ Mobile ◯ Other ◯

Alternate Number: _____ Home ◯ Work ◯ Mobile ◯ Other ◯

PREFERRED CONTACT: Phone ◯ Text ◯ Email ◯ Other ◯

CONTACT & DISCLOSURE INFORMATION

Please provide contact name in case of an Emergency:

_____ ◯ YES ◯ NO
Name of Individual Relationship to Patient Primary Phone # Leave a Message

Name of individuals to whom all of information about you may be disclosed:

1. _____ ◯ YES ◯ NO
Name of Individual Relationship to Patient Primary Phone # Leave a Message

2. _____ ◯ YES ◯ NO
Name of Individual Relationship to Patient Primary Phone # Leave a Message

If patient is a minor, please provide name of parent/guardian who is responsible for bringing the patient for treatment: _____

Parent/Guardian Name Relationship to Patient Primary Phone #

_____

Street Address City State Zip

PRIMARY / MEDICAL INFORMATION

_____

Primary Insurance Company Subscriber ID Group #

_____

Subscriber's Last Name First Name Relationship to Patient Date of Birth

_____

Secondary Insurance Company Subscriber ID Group #

_____

Subscriber's Last Name First Name Relationship to Patient Date of Birth

HEALTHCARE PROVIDER INFORMATION

Name of primary care Dr. : _____ Phone #: _____
Sleep Dr. : _____ _____Phone #: _____
Dentist: _____ _____Phone #: _____
Other Provider: _____ Phone #: _____

ALLERGIES

*Please indicate any known allergies & select severity of the reaction

□ Aspirin Mild Moderate Severe Reaction: _____
□ Codeine Mild Moderate Severe Reaction: _____
□ Iodine Mild Moderate Severe Reaction: _____
□ Latex Mild Moderate Severe Reaction: _____
□ Melatonin Mild Moderate Severe Reaction: _____
□ Metal Mild Moderate Severe Reaction: _____
□ Peanut Mild Moderate Severe Reaction: _____
□ Penicillin Mild Moderate Severe Reaction: _____
□ Plastic Mild Moderate Severe Reaction: _____
□ Sedatives Mild Moderate Severe Reaction: _____
□ Sleeping Pills Mild Moderate Severe Reaction: _____

□ Please list any other known allergies
□ _____ Mild Moderate Severe Reaction: _____
□ _____ Mild Moderate Severe Reaction: _____
□ _____ Mild Moderate Severe Reaction: _____

□ No known allergies

FAMILY HISTORY

*When selecting a condition, please indicate family relationship to you.

□ Bleeding disorder _____
□ Blood clotting disorder _____
□ Cancer _____
□ Cardiac disorder _____
□ Diabetes _____
□ Heart disease _____
□ High blood pressure _____
□ Obesity _____
□ Obstructive sleep apnea _____
□ Sleep disorder _____
□ Snoring _____
□ Stroke _____
□ Thyroid disorder _____
□ Problems w/ Mood/Mental _____

HABITS

*Please check applicable area(s) below:

Tobacco Use	None □	Rarely □	Moderate □	Daily □
Alcoholic Beverages	None □	Rarely □	Moderate □	Daily □
Recreational Drugs	None □	Rarely □	Moderate □	Daily □
Caffeine Use	None □	Less than 3 cups/day □	3-6 cups/day □	More than 6 cups/day □
Exercise	None □	Rarely □	Moderate □	Regular □
Eating Habits	Well □	Regular □	Poor □	
Smoking Status	Current □	Former □		

PAST / PRESENT MEDICAL HISTORY

*Please check applicable condition(s) you have had in the past: **Indicate "C" for Current or "P" for Past**

□ Acid reflux □ C □ P	□ Depression □ C □ P	□ Liver disease □ C □ P
□ Amnesia □ C □ P	□ Diabetes □ C □ P	□ Meniere disorder □ C □ P
□ Anxiety □ C □ P	□ Emphysema □ C □ P	□ Multiple sclerosis □ C □ P
□ Allergy-Nasal □ C □ P	□ Epilepsy □ C □ P	□ Neuropathy □ C □ P
□ Arthritis □ C □ P	□ Fibromyalgia □ C □ P	□ Osteoporosis □ C □ P
□ Asthma □ C □ P	□ Glaucoma □ C □ P	□ Pregnancy □ C □ P
□ Atrial fibrillation □ C □ P	□ GERD □ C □ P	□ Rheumatic fever □ C □ P
□ Autoimmune disease □ C □ P	□ Heart attack □ C □ P	□ Sinus pain □ C □ P
□ Bleeding disorder □ C □ P	□ Heart disease □ C □ P	□ Sleep apnea □ C □ P
□ Blood clotting disorder □ C □ P	□ Hepatitis □ C □ P	□ Stroke □ C □ P
□ Cancer □ C □ P	□ HIV □ C □ P	□ Tuberculosis □ C □ P
□ Chronic fatigue syndrome □ C □ P	□ High blood pressure □ C □ P	□ Thyroid disease □ C □ P
□ Congestive heart failure □ C □ P	□ Low blood pressure □ C □ P	□ Vascular heart disease □ C □ P
□ COPD □ C □ P	□ Insomnia □ C □ P	
□ Coronary heart disease □ C □ P	□ Kidney disease □ C □ P	

SOCIAL HISTORY

□ Family stress
□ Financial distress
□ Single □ Married □ Divorced □ Widowed
□ Children □ No children
Do you live alone? □ Yes □ No

□ Employed Occupation: _____
□ Unemployed
□ Retired
Diet □ Healthy □ Normal □ Restricted

SURGICAL HISTORY

□ Adenoidectomy
□ Appendectomy
□ Cholecystectomy
□ Coronary Artery Bypass Graft
□ Hernia Repair
□ Jaw Joint
□ Orthognathic
□ Prior Orthodontic Treatment

□ Sinus Surgery
□ Spinal Surgery, Cervical
□ Spinal Surgery, Lumbar
□ Temporomandibular Joint
□ Tonsillectomy
□ Uvulopalatopharyngoplasty – UPPP
□ Additional Surgeries: _____
□ _____
□_____

CURRENT MEDICATIONS

* If you have a list, a paper copy would be sufficient.

□ Name of medication	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EPWORTH SLEEPINESS SCALE

*Indicate below how likely you are to doze off (or fall asleep) in the following situations.

SITUATION	NEVER	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
As a passenger in a car for 1 hour without a break	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and reading	0	1	2	3
Sitting and talking	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Sitting quietly after lunch with no alcohol	0	1	2	3
Watching television	0	1	2	3

Total: _____

PATIENT CHIEF COMPLAINT

- ☐ CPAP intolerant(Complete Affidavit)
- ☐ Refuse CPAP
- ☐ Epworth SS Total :_____(> 10=EDS)
- ☐ Morning headaches
- ☐ Snoring affecting others
- ☐ Snoring reported
- ☐ Gasping causing wake
- ☐ Fatigue (mild /mold/severe)
- ☐ Impaired thinking
- ☐ Insomnia (mild/mod/severe)
- ☐ Dizziness
- ☐ Difficulty Concentrating
- ☐ Witnessed cessation of breathing at night
- ☐ Sleep Apnea (mild/mod/severe)
- ☐ Sleepiness while driving (mild/mod/severe)
- ☐ Forgetfulness
- ☐ TMD (mild/mod/severe)
- ☐ Bruxism □ Mild □ Moderate □ Severe
- ☐ Jaw Pain: Left/Right or Both
  Frequency of pain:_____
- ☐ Average hour of sleep per night: _____
- ☐ How long does it take you to fall asleep at night? _____
- ☐ Normal bed time: _____
- ☐ Sleep aid used:_____
- ☐ Naps per day: _____

ROS/General Symptoms <u>(Please CHECK if significant change in the last 6 months)</u>

- □ Health Status
  Mild / Moderate / Severe
- ☐ No Dreaming
- ☐ Weight Change
- ☐ Fever
- ☐ Chills
- ☐ Weakness
- ☐ Night sweats
- ☐ Change in appetite
- ☐ Recent trauma
- ☐ Recent infection
- ☐ Recent dental procedure
- ☐ Cold sensitivity
- ☐ Heat sensitivity
- ☐ Tires easily
- ☐ Hearing problem
- ☐ History of sinus infections
- ☐ Sinus Congestion
- ☐ Sore Throat
- ☐ Ringing in ears
- ☐ Gum pain
- ☐ Difficulty swallowing
- ☐ Bruxism/teeth grinding
- ☐ Dry mouth
- ☐ Rash
- □ Vomiting
- □ Nausea
- □ Diarrhea
- □ Constipation
- □ Reflux
- □ GERD
- □ Urinary Frequency
- □ Urinary Urgency
- □ Incontinence
- □ Frequent night urination
- □ Sexual Dysfunction
- □ TMJ issues
- □ Facial edema
- □ Headaches
- □ Dizziness
- □ Difficulty concentrating
- □ Bleeding tendency
- □ Bleeding gums
- □ Depression
- ☐ Facial edema
- ☐ Headaches
- ☐ Dizziness
- ☐ Difficulty concentrating
- ☐ Bleeding tendency
- ☐ Bleeding gums
- ☐ Depression
- ☐ Change in mood
- ☐ Anxiety
- ☐ Posttraumatic symptoms
- ☐ Psychiatric disorder other than mood:_____
- ☐ Excessive body movement while sleeping
- ☐ Restless legs at night
- ☐ Abnormal blood glucose
- ☐ Diabetes

SMITH
DENTAL SPECIALTIES

Limited to the practice of Dental Sleep Medicine & Orthodontics

Douglas E. Smith, DDS, D.ABDSM, D.ACSDD

CPAP INTOLERANCE/NON-COMPLIANCE AFFIDAVIT

It has been recommended and/or I have attempted to use CPAP (Continuous Positive Air Pressure) to manager my diagnosed Obstructive Sleep Apnea condition. I tried to use CPAP from _____ to _____ or approximately_____months/years.

I find CPAP intolerable to use on a regular basis due to:

_____Mask Leaks

_____Unable to sleep with CPAP mask and hose in place

_____I unconsciously remove CPAP at night

_____The noise from the machine disturbs my sleep

_____CPAP does not seem to be effective in reducing/eliminating my symptoms

_____I have tried multiple masks and none are comfortable enough to use

_____I develop sinus/ear/throat infections

_____I am claustrophobic

_____My job/lifestyle prevent nightly use (i.e., Military, Truck Driver, airline flights overnight)

_____Other:_____

Because of my intolerance and inability to use CPAP effectively to treat my condition, I wish to attempt an alternative therapy. I understand that the American Academy of Sleep Medicine Clinical Practice Guidelines for the treatment of Obstructive Sleep Apnea and Snoring with Oral Appliance Therapy recommends oral appliances rather than no therapy when it is prescribed by a sleep physician and the appliance is made by a QUALIFIED dentist. Dr. Smith is a Board Certified dental sleep medicine specialist who follows AASM guidelines by performing follow-up sleep testing to confirm treatment efficacy.

Patient Name:_____

Patient Signature:_____ Date:_____

Informed Consent for the Treatment of Sleep-Related Breathing Disorders

You have been diagnosed by your physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or obstructive sleep apnea (OSA). OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase a person's risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?

Oral appliance therapy for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder. A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. There are also reports of dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.

Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once oral appliance therapy is discontinued. If not reversible, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include behavioral modification, Continuous Positive Airway Pressure (CPAP) and various surgeries. It is your decision to choose oral appliance therapy to treat your sleep-related breathing disorder and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications. If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, please sign and date this form below. You will receive a copy.

Signature: _____ Date: _____

Print Name:_____

 x:ADSMConsentForm

Patient Name: _____ Date:_____

Patient Consent Because of HIPPA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By signing below, you permit the release of any information to or from Dr. Smith as required including a full report of examination findings, diagnosis, and treatment program to any y referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Dr. Smith may use your health care information and may disclose such information to your insurance company(ies) and their agents to obtain payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Patient or Guardian Signature Witness Signature

Consent for Medical Photography:

I consent for medical photographs to be made of me (or my child). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to those medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent, I will contact Dr. Smith's office and place my withdrawal in writing.

By signing this form below, I confirm that this consent form has been explained to me, if requested, in terms which I understand.

1. I consent for photographs to be used in medical publications. I understand that the image may be seen by members of the general public, in addition to scientists that regularly use these publications in their professional education. Although, these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for medical record.

   _____ _____

   Patient or Guardian Signature Witness Signature

2. I agree for my image to be shown for teaching purposes AND to be used for medical record but NOT FOR medical publications.

   _____ _____

   Patient or Guardian Signature Witness Signature

3. I agree to use of my image for medical records ONLY

   _____ _____

   Patient or Guardian Signature Witness Signature

SMITH

DENTAL SPECIALTIES

Douglas E. Smith, DDS, D.ABDSM, D.ABDSM, D. ACSDD
5102 Paulsen St., Bldg. 8, Savannah, GA 31405
912.655.8855 912.335.6564 f
smithdentalspecialties@gmail.com

FINANCIAL POLICY

We participate with many insurance plans, but not all. Keep in mind, it is the responsibility of the member/subscriber to understand coverage and to contact the insurance carrier directly to verify whether a plan covers the services we provide. Since we fabricate oral appliances, which are described by insurance as durable medical equipment, we make every attempt to complete precertification and verify benefits prior to the first appointment. This allows you, the patient, to have a better understanding of costs of treatment and allows us more time to discuss the pros and cons of treatment with you at the first appointment.

As a courtesy, we will file a claim on your behalf. It is the policy of Smith Dental Specialties to wait 45 days for a response from your carrier. In the event we have not received a response from your carrier within that 60 days, we will refer the balance not paid by the insurance carrier, including any non-covered services and balances applied to your annual deductible, to the attention of the patient/responsible party.

Co-pays, deductibles, and co-insurance payments are due and payable at time of visit. Co-insurance for an oral device for the treatment of sleep apnea, snoring, or TMJ will be set up on a monthly auto-billing payment plan, if needed. You will also be asked to make a payment if your account has an outstanding balance. If you are unable to pay towards your balance or do not have your co-pay amount, you will be asked to reschedule your appointment.

PATIENT RESPONSIBILITY

A statement will be sent to the patient's mailing address and payment is expected upon receipt. When you receive a statement from Smith Dental Specialties, you are expected to pay the balance upon receipt. If you do not agree with the balance due amount, you should call the phone number on the statement for an explanation of the balance and determining a payment plan, if necessary.

We reserve the right to charge the patient for missed appointments or when cancellations occur with less than 24 hours notice.

If you do not have insurance coverage, payment is expected at the time of service or payment arrangements may be made while you are at our office.

By signing this document, you understand that if a bill has to be turned over to a third-party collection agency for nonpayment, that there will be a collection fee added to my bill of 30%.

_____

Patient Name

_____ _____

Patient Signature Date

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND IOR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original..

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT. I GIVE PERMISSION TO SAVANNAH DENTAL SPECIALTIES TO RELEASE ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICES DESCRIBED ON EACH MEDICAL CLAIM FORM.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Pledge

We want you to understand that we respect your privacy. Other than the necessary uses and disclosures we described above, we will not sell your health information or provide any of your health information to any outside marketing company.

Uses and Disclosures

Below you will find examples of how we may have to use or disclose your health care information:
1. Your doctor or a staff member may have to disclose your health information (up to and including all of your clinical records) to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in our care or to facilitate the payment related to your care.
3. It may be necessary for the doctor and members of the staff to use your health information, examination, and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your doctor and members of the practice staff may need to use your information (ex. name, address, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine. As our patient, you posses the right to refuse to give us the authority to contact you regarding the above-mentioned circumstances. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
1. If we are providing services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency or disaster relief situation.
3. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
4. If we are provide health care services to you as a result of a Workers' Compensation injury.
5. If you are/ were a member of the armed forces, we are required by military command authorities to release your health information.
6. If we provide health care services to you as an inmate.
7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
Other than the circumstances described in the above examples, any other use or disclosure of your health information will only be made with your written consent.

Your right to revoke your authorization

You may revoke (take away) your privacy release authorization from us at any time; however, your revocation must be in writing. You can call for information about revoking your authorization during normal business hours, or send your request to the address listed below. There are two circumstances under which we will not be able to honor you revocation request.
1. If we have already released your health information before we received your request to revoke

your authorization. 164.508(b)(5)(i).
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at:

Office of Doug Smith DDS Orthodontics LLC
Smith Dental Specialties
5102 Paulsen Street, Bldg. 8
Savannah, GA 31405

Dr. Cynthia Hucks-Smith
Practice Manager

Your right to limit uses or disclosures
If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care form another health care provider.

Your right to receive confidential communication regarding your health information
We normally provide information about your health to you in person at the time you receive dental or medical services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information
You have the right to inspect and /or copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and / or copy your health information be in writing.

Your right to amend your health information
You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records
You have the right to request that we give you and accounting if the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:
• Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
• Those disclosures made to you.
• Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
• Those disclosures made for national security or intelligence purposes.
• Those disclosures made to correctional officers or law enforcement officers.
• Those disclosures that were made prior to the effective date of the HIPPA privacy law.

Our Duties
We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of our health information in our files.

Re-disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

For more information or to report a problem
If you have questions and would like additional information, you may contact our practice's Chief Privacy Officer at (912) 655-8855, or in writing to the Chief Privacy Officer, (5102 Paulsen Street, Bld.8, Savannah GA, 31405). If you believe your privacy rights have been violated, you can either file a complaint with this office or with the office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Georgia is as follows:
Office for Civil Rights. U.S. Department of Health and Human Services; Atlanta Federal Center, Suite 3870; 61 Forsyth Street, S.W.; Atlanta, GA 30303-8909

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy with this authorization at my request. This notice is effective as of the date I signed below. This authorization will expire seven years after the date in which you last received services from us.

ASSIGNMENT OF BENEFITS: I voluntarily direct _____
Insurance company to pay Doug Smith DDS Orthodontics LLC directly for charges for professional services rendered to me. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. I agree that I am responsible for any balance over and above insurance payment for these services. If my current insurance policy prohibits direct payment to Doug Smith DDS Orthodontics LLC, I instruct you to make the check to me and mail it as follows: Doug Smith DDS Orthodontics LLC, 5102 Paulsen Street, Bldg. 8, Savannah, GA 31405. I authorize Doug Smith DDS Orthodontics LLC, to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I understand and agree that if collection efforts are necessary to obtain payment on this account, I will be responsible for all costs of such collection efforts, including reasonable attorney fees. I understand that any unpaid balance will accrue monthly interest at 1.5-% after 30 days of delinquency, unless prior payment arrangements are made.

CONSENT TO TREAT: I voluntarily authorize Doug Smith DDS Orthodontics LLC and whomever Doug Smith DDS Orthodontics LLC designates as assistants or associates to administer examinations and care as deemed necessary for my condition.
Emergency Contact Name: _____ Phone: _____

AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case. I have been given an opportunity to read, discuss, and keep a copy of this page and the previous two pages.

_____ _____
Patient Name Printed Date

_____ ___
Patient Signature Witness Signature