HARBORVIEW DENTAL

PATIENT INFORMATION

FIRST NAME: LAST NAME:

DATE OF BIRTH: GENDER:

SOCIAL SECURITY:

PHONE:

EMAIL:

ADDRESS:

CITY: STATE: ZIP:

LEGAL MARITAL STATUS:

OCCUPATION:

EMPLOYER/ SCHOOL:

REFERRED BY:

EMERGENCY CONTACT NAME:

RELATION: PHONE

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? YES ---------- NO -----

Primary Insurance (Insurance company that pays first)

NAME:

MEMBER ID:

GROUP NUMBER:

ADDRESS:

CITY: STATE: ZIP:

Primary Insurance Subscriber/Policyholder Information:

FIRST NAME: LAST NAME:

DATE OF BIRTH: SOCIAL SECURITY:

RELATIONSHIP TO POLICY HOLDER:

PHONE:

ADDRESS:

CITY: STATE: ZIP:

EMPLOYER:

SECONDARY INSURANCE (Insurance that pays second)

NAME:

MEMBER ID:

GROUP NUMBER:

ADDRESS:

CITY: STATE: ZIP:

ARE YOU UNDER THE CARE OF A PHYSICIAN?

YES---------- NO ----------

PHYSICIAL NAME: PHONE NUMBER:

HAVE YOU HAVE ANY SERIOUS ILLNESS, OR BEEN HOSPITALIZED IN THE PAST 5 YEARS?

YES---------- NO ----------

IF YES, PLEASE EXPLAIN:

DO YOU REQUIRE PROPHYLACTIC **ANTIBIOTIC** BEFORE ANY DENTAL TREATMENT?

YES---------- NO ----------

ALLERGIES o **NO ALLERGIES**

IF YES, PLEASE LIST ALL ALLERGIES AND REACTIONS

MEDICATIONS **o NO MEDICATIONS**

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING INCLUDING THE DOSES

MEDICATIONS	DOSE

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	YES	NO
Cardiovascular / Heart disease		
Angina/ chest pain		
High blood pressure		
Depression/Anxiety/Bipolar/Suicidal		
Diabetes		
Emphysema *(COPD)*		
Mitral Valve prolapse		
Congenital Heart Defect		
Pacemaker		
Abnormal bleeding		
Anemia		
AIDS or HIV infection		
Stroke		
Autoimmune disease		
Asthma		
Tuberculosis		
Cancer/ chemotherapy/ radiation therapy		
Gastrointestinal disease		

Thyroid problems		
Hepatitis or liver disease		
Fainting spells or seizures		
Kidney disease		
Osteoporosis		
Sexually transmitted disease		

FEMALES ONLY

Are you pregnant?		
Are you Nursing?		
Do you take any Birth control pills?		

ANY OTHER DISEASE OR PROBLEMS NOT LISTED ABOVE? IF YES, PLEASE SPECIFY:

_____

_____

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Harborview Dental (Modern Dental Arts, PA) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Modern Dental Arts, PA. I understand that diagnosis or treatment of me by Modern Dental Arts, PA may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my doctor, another health care

provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future dental, physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Modern Dental Arts, PA Notice of Privacy Practices prior to signing this document. The Modern Dental Arts, PA Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Modern Dental Arts, PA The Notice of Privacy Practices for Modern Dental Arts, PA is also provided at 34669 US Highway 19 North, Palm Harbor, FL 34684. This Notice of Privacy Practices also describes my rights and the duties of Modern Dental Arts, PA with respect to my protected health information. Modern Dental Arts, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this dentist or supplier, any information needed for this or a related Medicare or insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of dental insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Modern Dental Arts, PA.

I may obtain a revised Notice of Privacy Practices by requesting in writing from Harborview Dental or asking for one at the time of my next appointment.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Modern Dental Arts, PA (Harborview Dental) for all covered dental services and supplies provided to me during all courses of treatment and care provided by MDA and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with Harborview Dental, which will authorize and allow for direct payment to Harborview Dental of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Harborview Dental.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Modern Dental Arts, PA (Harborview Dental) and or its affiliated entities for any charges not covered by my dental benefits. It is my responsibility to notify Harborview Dental of any changes in my insurance coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Harborview Dental and/or my dental insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for dental services and/or supplies received.

This is an agreement between Modern Dental Arts, PA a private dental office, DBA Harborview Dental, and the Patient/Debtor named on this form.

Insurance: Insurance is a contract between you and your insurance company. In some cases exact insurance benefits cannot be determined until the insurance company received the claim. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please understand that insurance reimbursement can be delayed for multiple reasons. In fat, insurers will routinely stall, deny, and reduce payment. Insurers routinely process claims resulting in additional invoicing at no fault of Harborview Dental. We will NOT under any circumstances falsify or change a diagnosis or symptom in order to convince an insurer to "pay" for care that is not covered, nor do we delete or change the content in the record that may present, or cause, it to be considered covered.

24- HOUR Cancellation & "No Show" Fee Policy

Each Time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, our office reserves the right to charge a fee of $50.00 for each missed appointments (no shows), or appointments cancelled without at least 24 hour advanced notice.

It is ever patient's responsibility to remember their scheduled appointments Patient will receive an appointment card for their appointments if they are in office (unless the patient refuses

one). Reminder calls and texts are an office courtesy and should not be solely relied on. "NO SHOW" fees will be billed to the patient. This fee is not covered by insurance, and must be paid by the patient. Multiple cancellations or "no shows" may result in termination from our practice.

Guarantee of Payment

For valued received, including but not limited to the services rendered, I agree to guarantee and promise to pay Harborview Dental all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/ or deductible.

Unless specifically agreed in writing, all charges shall be paid at discharge or upon presentation of the first bill by Harborview Dental.

I understand that Harborview Dental can send me a " pay by text" message or an invoice in the mail.

I understand that Harborview Dental reserves the right to call to collect a payment by phone. Unpaid accounts shall bear interest at the maximum rate provided by Florida law (rate is 12%).

I understand that Modern Dental Arts, PA will provide its patients a grace period of up to 90 days. I understand that Modern Dental Arts, PA is contracted with a collection agency (IC systems) and is entitled to send any unpaid balance that are over 90 days to collections. Patients are responsible to pay any open statements and MDA is not required to send any payment notices or payment reminders.

I understand and agree that if Harborview Dental is required to bring a claim or file an action to enforce this agreement, Modern Dental Arts, PA (DBA Harborview Dental) shall be entitled to recover from me its reasonable attorney's fees, expert fees, court costs, and any other Fair Credit Reporting Act, Harborview Dental reserves the right to run a credit report for the sole purpose of determining my ability to meet incurred expenses directly related to my treatment.

PAYMENT RECEIVED WILL BE POSTED TO THE OLDEST OUTSTANDING BALANCE ON YOUR ACCOUNT.

Notice of Billing Efforts Conducted Via Electronic Means

I understand that in its regular course of billing and collection efforts, Harborview Dental may communicate with me via electronic means and that any phone number (including cellular phone numbers) and/or email address provided to Modern Dental Arts, PA may be used for these purposes. I consent to the use of e-mail, text or automated voicemail communication by Harborview Dental if I have any balances due on my account, regardless of my Preferred Contact selection(s) for communication of protected health information (PHI) via electronic means. I understand that contacts may be made as a direct dial call or through the use of email, text messages, pre-recorded or artificial voice messages, and/or the use of an "automated telephone dialing system" or "auto dialer". I understand that message and data rates may be assessed by my mobile provider.

AUTHORIZATION TO COMMUNICATE VIA ELECTRONIC MEANS

I AUTHORIZE MODERN DENTAL ARTS, PA (HARBORVIEW DENTAL) TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS OF TEXT, EMAIL, OR A VIDEO CONFERENCE.

I understand by selecting the method of communication above and signing below, I authorize Harborview Dental to share/communicate PHI information via electronic means to myself or my designated representative described above.

I understand Harborview Dental may communicate to me information such as when I have an upcoming appointment, services recommended by my doctor, medication refills, new services offered, financial information or statements and new locations/providers at Harborview Dental.

I understand that according to HIPAA Privacy Rule § 164.501, Harborview Dental cannot sell or distribute my communication method or information with any third-party without my prior consent.

I understand that, by federal law, Harborview Dental may not use or disclose my health information without my in person written authorization, except as provided in Harborview Dental's Notice of Privacy Practices. I hereby release Harborview Dental and its employees from any and all liability that may arise from the release of information as I have directed.

I understand emailing and texting are not secure forms of communication and I release Harborview Dental from any liability.

I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization to communicate PHI via electronic means and that I cannot be denied.

Consent to Dental Photography

I authorize Providers and staff of Harborview Dental to take photographs and/or videos of my face, mouth, teeth, and jaws, before and after treatment.

I consent to allow the photographs to be used for the following professional purposes:

Dental Records , Dental Research, or Dental Education, for myself and others, including but not limited to training purposes, lectures, presentations, etc.

Marketing material and advertisements, including limited use on social media, websites,

printed materials, and in-office demonstrations. **I further understand that if the photographs and/or videos are used, my name and other identifying information will be kept confidential.**

I do not expect compensation, financial or otherwise, for the use of my photographs and/or videos.

I understand that the practice cannot condition the treatment I do or do not receive based on whether or not I sign this authorization.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Advanced Oral Cancer Screening Informed Consent

Nature of Advanced Oral Cancer Screening Treatment:

To provide optimum screening and oral health care, in addition to the visual and palpable tissue exam that will be provide at each dental exam, advanced oral tissue screening technology is offered for all adult and high risk patients annually as a standard of care. This lifesaving standard is proven for early detection of cancers.

- I understand that while the visual and palpable exam reveals dangerous lesions that are in the later stages, suspicious tissues are most treatable, with lowest risk of mortality, in the earliest stages.
- I understand advanced screening (florescence)technology is used to effectively examine tissues for abnormalities in the earliest stages that are not visible to the unaided eye. This additional step in the tissue exam is not a diagnostic tool, however, itis effective as an enhanced screening tool.
- I understand consenting to this annual advanced oral cancer screening will allow my dental providers to perform the most thorough and enhanced screening to decipher between healthy tissues and suspicious lesions.
- I understand refusing the use of this advanced technology will not allow my provider to inform me of lesions unseen without this technology.
- I understand early detection is my best opportunity to seek treatment when recovery is minimal, and risk of mortality is lowest
- Risks include additional testing, as use of this technology could lead to need for a biopsy if tissues appear abnormal.
- Alternative evaluations could include testing with Toluidine Blue as an adjunctive for recognizing and identifying the extent early of abnormal tissues.

PLEASE CHOOSE **ONE:**

- I authorize my dental provider(s) at Harborview Dental to perform the advanced oral cancer screening along with the visual and palpable exam as a standard of care.
- I decline to authorize this advanced oral cancer screening and understand that refusing the use of this advanced technology will not allow my provider to inform me of lesions unseen without this technology. I am also aware that, as a standard of care, I will be offered the opportunity to receive this screening annually.

Consent for Cone Beam Computerized Tomography (CBCT)

Facts for Consideration

A Cone Beam Computerized Tomography (CBCT) scan, is an X-ray technique that can produce three-dimensional (3-D) images of your head and allows visualization of internal bony structures in cross section rather than as overlapping images typically produced by conventional two-dimensional (2-D) X-ray exams. Dentists use CBCT scans to visualize many areas, including bony structures, such as your teeth and jaws, but not necessarily soft tissue, such as your tongue or gums.

Risks of CBCT Scan, Not Limited to the Following:

- CBCT scans, like conventional X-rays, expose you to radiation. The dose of radiation used for the CBCT scan is controlled to allow the smallest dose used that will still give sufficient data to achieve a useful result. The dosage per scan is equivalent to two (2) regular dental X-rays.
- X-ray imaging of the mouth is generally not contraindicated in pregnancy and should be utilized as required to complete a full examination, diagnosis and treatment plan. Please advise your dentist if you are pregnant or planning to become pregnant,
- The CBCT scan may or may not reveal coincidental medical findings unrelated to your dental condition, dental care and dental treatment. A CBCT scan is a diagnostic procedure intended solely to facilitate diagnosis of your dental condition and your dental care and to help plan your dental treatment.

Alternatives to CBCT Scan, Not Limited to the Following:

- Conventional X-rays: They limit your dentist to evaluating anatomical structures in a two-dimensional view and increase the risk of missing important diagnosis.
- I consent to have the above-mentioned CBCT scan.
- While the scan may be covered by my medical and/or dental insurance, I accept any financial responsibility for this scan and authorize the scan. =

Refusal

□ I refuse to give my consent for the proposed CBCT scan described above and understand the potential consequences associated with this refusal. **Note:** Failure to have a CBCT scan may result in failure to detect or diagnose significant disease and associated potential harm.

Patient Name Date

Patient Signature