Lone Star
Family Dental
Justin McElvain, DDS

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____
Social Security Number:_____ Driver's License State/#:_____
Street Address:_____ City, State, Zip:_____
Home Phone:_____ Work Phone: _____ Cell:_____
Email Address:_____ Sex (circle one): Male Female
Marital Status (circle one): Married Divorced Single Separated Widowed
Emergency Contact Name and Phone Number:_____
How did you hear about our office? _____

DENTAL INSURANCE

Policy Holder Name: _____ Date of Birth: _____
Social Security Number: _____ Employer: _____
Insurance Company: _____ Insurance Phone #: _____
Group #: _____ ID #: _____Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH _____ INSURANCE COMPANY AND ASSIGN DIRECTLY TO DR. MCELVAIN ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TIME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. DR. MCELVAIN MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED.

_____ _____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE PRINTED NAME

_____ _____
RELATIONSHIP TO PATIENT DATE

DENTAL HISTORY

Reason for today's visit:_____
_____
Former Dentist: _____
City/State: _____
Date of last dental visit: _____
Date of last dental X-rays: _____

"X" the box to indicate you have had any of the following:

- Bad Breath
- Bleeding gums
- Blisters on lips or mouth
- Burning sensation on tongue
- Clicking or popping of jaw
- Sores or growths in your mouth
- Dry Mouth
- Fingernail biting
- Food collection between teeth
- Grinding teeth
- Gums swollen or tender
- Lip or cheek biting
- Loose teeth or broken fillings
- Mouth breathing
- Mouth pain when brushing
- Orthodontic treatment
- Periodontal treatment
- Sensitivity when biting
- Sensitivity to heat
- Sensitivity to cold
- Sensitivity to sweets
- Pain around ear
- Chew on one side of mouth

How often do you floss? _____
How often do you brush? _____

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HIPAA CONSENT AND PRIVACY AUTHORIZATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(You May Refuse to Sign This Acknowledgement)

I have received a copy of this practices' Notice of Privacy Practices.

Patient Name: _____

Patient Signature: _____ Date: _____
(Or responsible party if patient(s) under 18)

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your/your child's 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/your child's protected health in formation, and of other important matters about your/your child's 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/your child's 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:

Privacy Officer Contact

Paige McElvain	Telephone:	(214) 383-2626
Practice Director	Address:	431 Stacy Rd Suite 108 Fairview, TX 75069

(OVER)

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.

SIGNATURE OF CONSENT

I 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/my child's protected health information to carry out treatment, payment activities and health care operations.

Patient Name: _____

Patient Signature: _____ Date: _____
(Or responsible party if patient(s) under 18)

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my/my child's 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.

Patient Name: _____

Patient Signature: _____ Date: _____
(Or responsible party if patient(s) under 18)

NOTE: You are entitled to a copy of this consent after you sign it. (available upon request)

This form is educational only, does not constitute legal advice, and covers only federal, not state, law. (August 14, 2002).

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INFORMED CONSENT

I, _____, do hereby authorize Lone Star Family Dental and its licensed clinical staff to take photographs, x-rays and/or videos of my or my dependant(s)' face, jaws, hard and/or soft tissues of my mouth and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of dental needs. I understand that these photographs, x-rays, videos, and diagnostic aids will be part of my or my dependant(s)' permanent dental record.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

DEPENDENT(S) NAME (if applicable) _____

_____

_____

_____

_____

_____

SIGNATURE

Patient: _____ Date: _____
(Or responsible party if patient(s) under 18)

Practice Representative: _____ Date: _____

!!!DO NOT SIGN UNTIL YOU HAVE READ & UNDERSTAND EVERYTHING!!!

Please ask if you have any questions.

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PAYMENT POLICY

In order to keep our fees from rising, and at the same time keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients these payment policies. This will help reduce our overhead, enabling us to pass the savings along to our patients.

1. Payment is expected at the time the service is rendered. We will accept cash, personal checks, and the following credit cards: Visa, MasterCard, Discover, American Express, and Care Credit. RETURNED (bounced) CHECKS RESULT IN A $45.00 CHARGE ON TOP OF UNPAID BALANCE.
2. Non-insured patients are expected to make payment in full on the day the service is rendered.
3. Patients with dental insurance are expected to pay, on the day of service, that portion of the total fee not covered by their insurance. This "patient portion" is ONLY an estimated dollar amount.

As a COURTESY to our insurance patients, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow, however if we do NOT receive payment from your insurance company within 60 days, the payment becomes your responsibility. We do not know nor is it our responsibility to know every detail of your insurance policy. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE POLICY'S LIMITATIONS. We try our best to give you a general picture of your policy however it is still your responsibility to know and accept the limitations of your insurance policy.

1. In the event that your balance is unpaid by your insurance company within 60 days of the date the services are rendered, you will receive a phone call notifying you of your responsibility and a statement will be processed and mailed to you that same day. Payment of your remaining balance will be expected within 30 days of the statement date. In the unfortunate event that payment is not received within 30 days of the statement date, a late charge of 10% will be added to the original balance of which will also be your responsibility. In the event that your balance is unpaid within 60 days of the original statement date, our only option left will be to take corrective legal action.

2. The patient is always responsible for seeing that the ENTIRE FEE is paid in full.

MAKE NOTE!

3. **REGARDING RESERVATION CANCELLATIONS:** Appointments missed or cancelled, without a 48-hour notice, will result in a $50 cancellation charge. Appointments are specifically made to set aside time for patients with an agreement that they will make the appointments. When an appointment is made for a patient, no other patient can use that time slot. A missed appointment WITHOUT advanced, proper notice results in a costly expense to the practice and a discourtesy to other patients needing that time. Making a scheduled appointment on time is a way a patient can help reduce overhead expenses thus enabling us to pass the savings on to you.

4. **REGARDING NON-REFUNDABLE DEPOSITS FOR LONG RESERVATIONS:** You may be asked to prepay a non-refundable deposit in order to secure a long reservation with Dr. McElvain. This deposit will be non-refundable and will apply towards your treatment. In the event that you cancel or miss this type of long-appointment reservation without 72 hours advanced notice, you will forfeit your deposit.

I have read the above policies and agree to abide by them. I/WE understand and agree that in the event of default, to pay all reasonable collection charges and/or attorney fees.

Name:_____ Sign:_____ Date:_____

FOR REFERENCE ONLY

You may discard after use

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NOTICE OF PRIVACY PRACTICES

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

This practice is required, by law, to maintain the privacy and confidentiality of our protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or health care operations. (example)

> "On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with this practice."
>
> "It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation
We may disclose your health information as necessary to comply with the State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for the purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health and safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes, as described below: (example)

> "As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with a person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Change of Ownership
In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights
- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required by law to agree to the restriction that you requested.
- You have the right to have your health information.
- You have the right to inspect and copy your health information.
- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Privacy Officer by calling this office.

Privacy Officer Contact

Paige McElvain	Telephone:	(214) 383-2626
Practice Director	Address:	431 Stacy Rd Suite 108 Fairview, TX 75069

Complaints
Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave, S.W.
Room 509F HHH Building
Washington, DC 20201