FLOSS

DENTISTRY REDEFINED

GETTING TO KNOW YOU

Name: _____ Sex: M _____F_____

Home Phone:_____ Work:_____ Cell: _____

Email Address:_____ Social Security #:_____ Date of Birth:_____

Home Address:_____ City:_____ Zip Code:_____

Drivers License Number: _____ State: _____ Exp. Date: _____

Previous Dentist:_____ Phone: _____

Whom may we contact in the case of an emergency?_____ Phone:_____

Is it okay to use email to communicate with you (Please Circle)? YES NO
How about text (Please Circle)? YES NO

If you would like, tell us something interesting about you…

How did you hear about FLOSS? We want to thank them personally…

☐ Existing Patient: _____ ☐ Insurance ☐ Yelp ☐ Google ☐ Drive By ☐ Facebook

☐ FLOSS Website ☐ Another FLOSS location: _____ ☐ Community Event: _____

☐ Other:_____

EMPLOYER AND INSURANCE INFORMATION

Employer Name and Address:_____
Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ Social Security Number: _____
Insurance Company: _____ Group #:_____ Member ID# _____
Spouse's Name:_____ Work Phone:_____
(Spouse) Social Security #:_____ Date of Birth: _____

Do you have Secondary Insurance (Please Circle)? YES NO

Name of Insured: _____Relationship to Patient: _____
Birthdate: _____ Social Security Number: _____
Name of employer: _____ Office Phone: _____
Insurance Company: _____ Group #: _____ Employer/ID# _____

Date of Last Dental Exam: _____ Reason for Today's Visit: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

Patient/Guardian Signature: _____ Date: _____

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the densitry you will receive. Thank you for answering the following questions;

Are you under a physician's care now? Yes No If yes, please explain _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain_____

Have you ever had a serious head or neck injury? Yes No If yes, please explain_____

Are you taking any medications, pills or drugs? Yes No If yes, please explain_____

Do you take or have you taken Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you snore? Yes No

Have you been diagnosed with sleep apnea? Yes No

Women:
Taking oral contraceptives?
Pregnant/Trying to get pregnant? Nursing?

Are you allergic to any of the following (please circle any/all that apply)? If no known drug allergies, please circle NONE.

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs NONE

Other _____

Do you have or have you had any of the following?

AIDS/HIV Positive	**Chest Pains**	**Frequent Headaches**	**Irregular Heartbeat**	**Scarlet Fever**	**High Cholesterol**
Alzheimer's disease	**Cold Sores/Fever Blisters**	**Genital Herpes**	**Kidney Problems**	**Shingles**	**Osteoporosis**
Anaphylaxis	**Congenital Heart Disorder**	**Glaucoma**	**Leukemia**	**Sickle Cell Disease**	
Anemia	**Convulsions**	**Hay Fever**	**Liver Disease**	**Sinus Trouble**	
Angina	**Cortisone Medicine**	**Heart Attack/Failure**	**Low Blood Pressure**	**Spina Bifida**	
Arthritis/Gout	**Diabetes**	**Heart Murmur**	**Lung Disease**	**Stomach/Intestinal Disease**	
Artificial Heart Valve	**Drug Addiction**	**Heart Pace Maker**	**Mitral Valve Prolapse**	**Stroke**	
Artificial Joint	**Easily Winded**	**Heart Trouble/Disease**	**Pain in Jaw Joints**	**Swelling of Limbs**	
Asthma	**Emphysema**	**Hemophilia**	**Parathyroid Disease**	**Thyroid Disease**	
Blood Disease	**Epilepsy or Seizures**	**Hepatitis A**	**Psychiatric Care**	**Tonsillitis**	
Blood Transfusion	**Excessive Bleeding**	**Hepatitis B or C**	**Radiation Treatments**	**Tuberculosis**	
Breathing Problem	**Excessive Thirst**	**Herpes**	**Recent Weight Loss**	**Tumors or Growths**	
Bruise Easily	**Fainting Spells/Dizziness**	**High Blood Pressure**	**Renal Dialysis**	**Ulcers**	
Cancer	**Frequent Cough**	**Hives or Rash**	**Rheumatic Fever**	**Venereal Disease**	
Chemotherapy	**Frequent Diarrhea**	**Hypoglycemia**	**Rheumatism**	**Yellow Jaundice**	

Have you ever had any serious illness not listed above? Yes No If yes, please explain_____

Comments_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT/PARENT/GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

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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.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Jim Moore, CHP – 618.708.1500

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by Federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for procedures may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and staff training.

For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses. We may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "Business Associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a Business Associate involves the use or disclosure of your protected health information, we will have a written agreement with that Business Associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your

authorization. We may also send you information about products or services that we believe may be beneficial to you. You may request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable Federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Workers' Compensation: We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please ask your doctor if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to a staff member in our office. The staff member will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff member provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please ask your doctor if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Jim Moore, a Certified HIPAA Professional. You may contact our Privacy Officer in writing at our office address or by calling 618.708.1500. Our website may offer additional information about the complaint process.

This notice was published and becomes effective on July 1, 2015.

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FLOSS BILLING PROCESS

Thank you for choosing FLOSS Dental. In efforts to better serve you, we would like to take the time to explain the billing process at our office.

Once you provide the office with your dental insurance, we call your insurance company and verify your benefits. The information we receive from your insurance company is only an estimation of coverage and not a guarantee. After you have been seen in our office, we will file your claim to the insurance company directly. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and be responsible for the remaining account balance.
Thank you again for choosing FLOSS Dental for your dental needs. We look forward to a long lasting relationship with you.

I have read and understand the billing process at FLOSS Dental.

_____

Patient/Parent/Guardian Name (Printed)

_____

Patient/Parent/Guardian Signature Date

PRACTICE POLICIES

Our goal is to provide quality dental care in a timely manner. In order to do so we have had to implement a cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT
In order to be respectful of other patients' needs, please call our office promptly if you are unable to attend an appointment. We ask that you call 24 hours in advance to reschedule/cancel. A no show/no call will result in a cancellation fee.

NO SHOW POLICY
A "no show" is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will result in a fee of $50 for every half hour scheduled.

LATE ARRIVALS
In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

CELL PHONE POLICY
As a courtesy to other patients and in an effort to maintain our schedule, we request that cell phones be put away while the doctor, hygienist, or assistant is in the room with you.

I have read and understand the "Practice Policies".

_____

Patient/Parent/Guardian Name (Printed)

_____

Patient/Parent/Guardian Signature Date

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CONSENT TO TREATMENT FORM

This consent covers all dental services rendered to me by Mode Floss, PLLC, its affiliates, and its and their employed and contracted dentists (collectively, "**Practice**"). The duration of this consent is indefinite and continues until revoked by me in writing. I understand I may revoke this consent by informing the Practice in writing, but if I do revoke, it will not affect anything done prior to the date the revocation is received.

Please read this form carefully, and feel free to ask us if we can explain anything more clearly. **PLEASE INITIAL AND SIGN THE FOLLOWING AS APPROPRIATE.**

_____ **Minor/Disable Patient**: I understand that I am signing this consent on behalf of a patient who is under age 18 or impaired in such a way as to make him or her unable to consent to or refuse treatment, I represent to Practice that I have the legal authority to consent to treatment on such patient's behalf. All references in the form to "I", "me," or "my" are intended as references to such patient where appropriate in the context.

_____ **Treatment**: I authorize Practice, assisted by dental auxiliaries of its choice, to perform the following dental treatment, if needed or recommended: examination of the teeth, mouth and neck, radiographs (e.g., x-rays) of the teeth and jaws, cleaning of the teeth and application of fluoride, application of plastic dental sealants to the grooves of molars, use of local anesthesia to numb the teeth and surrounding tissues, treatment of injured or diseased teeth with tooth colored fillings (composites) and crowns (stainless steel or composite), pulpotomy or root canal treatment of diseased nerve), extraction of diseased, nonrestorable teeth, or extractions requested by an orthodontist, replacement of extracted or missing teeth with a space maintainer or dental prosthesis to help preserve the position and health of the surrounding teeth and tissues, treatment of malposed (crooked) teeth, and use of nitrous oxide to reduce anxiety. The dentist(s) have explained the nature and purpose of the treatment and procedures to me in general terms. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages, disadvantages, risks, consequences and probable effectiveness of each, as well as prognosis if no treatment is provided. I am advised that though positive results are anticipated, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.

_____ **Consent for Photography:** I consent to have my image taken by Practice and understand that all photographs, radiographs, videos, digital, and other images of me may be recorded to document and assist with my care and the payment of my bill. I understand the images will become part of my dental record and therefore protected, used and/or disclosed in accordance with Practice's Notice of Privacy Practices. I understand that Practice will own these images, but that I will be allowed to access or view them or to obtain copies of them as part of my dental record.

_____ **Notice Privacy Practices Acknowledgment:** I acknowledge receipt of the Notice of Privacy Practices with detailed information about how Practice may use and disclose my protected health information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

_____ **Authorization to Leave Message:** I authorize and indemnify Practice to communicate any follow up dental results using the primary phone number I listed on the Practice check-in paperwork. If there is no answer, I authorize Practice and its providers to leave a detailed message (which may include my protected health information) regarding my treatment. I understand that I have the right to change the contact information at any time and have the responsibility to update any changes to the contact information.

_____ **Consent to Release to Family/Friends and Others:** I consent to Practice disclosing and releasing financial and dental information regarding my treatment to the following individuals:

Name:_____

Relationship to Patient:_____

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Name:_____

Relationship to Patient:_____

I have read and understand this form, I have been given an opportunity to ask questions, and all questions I have asked have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions which may arise during the course of my treatment.

Assignment of Benefits - Financial Agreement Acknowledgement

I authorize my insurance benefits be paid directly to Practice or its designated billing agency. I also consent to Practice and its providers releasing all information necessary to my insurance company when requested and to facilitate the payment of my claim(s). I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. In the event of my default, or other non-payment of my bill, I agree to pay all costs of collections, and reasonable attorney's fees and court costs due, in addition to the amount due. To the extent applicable, as the parent, guardian, or guarantor of the patient, I agree to be responsible for all services rendered. I hold Practice harmless for attempts to collect regardless of parental, guardian or guarantor financial responsibility. I agree to be responsible for payment regardless of any divorce, separation, or other outside agreements that may or may not be in effect at the time of service.

****BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS CONSENT FORM AND THE NOTICE OF PRIVACY PRACTICES. I ALSO ATTEST THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE ASSIGNEMENT OF BENEFITS – FINANCIAL AGREEMENT ACKNOWLEGEMENT.****

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE**

_____

PRINTED NAME

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)