Office Policies

Welcome!

Dr. Aaron White has over 10 years of experience providing straight and healthy smiles for children, teens, and adults. After graduating near the top of his class, Dr. White was commissioned a Captain in the U.S. Air Force. He also completed an Advanced Education in General Dentistry (AEGD) residency, where he graduated as #1 in his class. Later in 2008, he completed his orthodontic residency program in San Antonio, becoming the youngest orthodontist ever in the U.S. military.

Georgetown Family Orthodontics is pleased to offer comprehensive orthodontic treatment for our patients **and** their families! Thank you for entrusting us with your orthodontic care. Orthodontic treatment can improve overall oral health, while increasing confidence and boosting self-esteem. New technologies, such as invisible aligners and improved techniques have brought new levels of efficiency and comfort to our patients. In addition, research indicates that patients who receive early or interceptive treatment may significantly reduce the length and difficulty of treatments later on. From children and teens to adults alike, we will customize a treatment plan best suited to your needs and lifestyle.

In order to enhance communication and promote an understanding of how our office operates, please read the following information carefully:

Financial/Insurance Policy:

We will gladly accept any **PPO** dental insurance plans. If we are contracted with your insurance plan, we will file orthodontic claims on your behalf and accept assignment of benefits (payment) from your insurance company. Dr. Aaron White is currently contracted (in-network) with MetLife & United Concordia TDP dental plans.

Prior to starting treatment, you will be given a treatment plan that includes an estimated insurance portion. Please be aware, benefit information given to us by your insurance company is termed an "*estimate only*". The benefits you receive may differ from what you are expecting.

Typically, insurance companies issue payment for orthodontic treatment over time as treatment progresses. If your insurance policy terminates prior to your insurance company paying the estimated insurance portion on your treatment plan, you will be billed for the remaining balance. With that said, we are committed to helping you maximize the use of your insurance benefits. We strive to provide complete and accurate information to your insurance company in a timely manner to ensure they can effectively process your claims.

If the patient is covered by more than one dental insurance plan, please be aware of the industry guidelines that determine which plan is considered primary and which is considered secondary. Insurance claims must be sent to your primary insurance company prior to submitting a claim to your secondary insurance plan.

We offer different payment options to help your family's budget for orthodontic care–our Treatment Coordinator will discuss this with you.

Appointment Policy:

Schedule permitting, we allow a 5-10 minute grace period for late arrivals of orthodontic appointments. We ask that patients please inform our office as soon as possible if a late arrival is likely. All appointments will be automatically rescheduled after 15 minutes if we cannot reach you by phone in order to accommodate our other patients.

By providing your signature below, you indicate that you have read, fully understand, and agree to our office policies.

Signature: _____ **Date:** _____

Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____ Gender: □ M or □ F

Date of Birth: _____ Age: _____ SSN: _____

Address (#, Street, City, State, Zip): _____

_____

Emergency Contact (Name, Relationship and Phone Number):

_____

If the above mentioned is under 18, please complete the information below:

Guardian 1:

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____

Date of Birth: _____ SSN (insurance purposes): _____

Relationship and Phone Number:

_____

Guardian 2:

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____

Date of Birth: _____ SSN (insurance purposes): _____

Relationship and Phone Number:

_____

With whom does the patient primarily reside with? _____

Appointment Reminders:

□ Please send me email and/or text message reminders about my appointments.

Email address (additionally used for email correspondence by our Treatment Coordinator):

_____

Phone to text: _____

□ I prefer a phone call reminder for my appointments. Best Number: _____

PRIMARY Dental Insurance Information:

Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's Employer: _____

Insurance Company Name: _____

Address & Phone Number: _____

Group#: _____ Member #: _____

How Did You Hear About Us?

□ Community Impact, □ Focus Magazine, □ View Magazine, □ Facebook, □ School Talk, □ Google, □ Macaroni Kids Newsletter,

□ Other family members seen here _____

□ Referral by Friend _____

□ Referral by Family Physician _____

□ Other _____

Do you have a personal or business website, blog, twitter, or other social media outlet that you would like to share with us?

If so, please list: _____

Dental History:

(you may leave this section blank if you are a patient of record at our office)

General Dentist:_____ Phone Number _____

City & State: _____ Date of last cleaning: _____

Why are you seeking orthodontic care? _____

_____

How would you currently rate your smile? (circle one) Worst 1 2 3 4 5 6 7 8 9 10 Best

Please list any concerns you have about braces: _____

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

Do you *CURRENTLY* have any of the following habits?

Lip Sucking/Biting	□ Yes or □ No	Teeth Grinding	□ Yes or □ No
Thumb/Finger Sucking	□ Yes or □ No	Mouth Breathing	□ Yes or □ No
Nail Biting	□ Yes or □ No		

Do you have any ringing in the ears? □ Yes or □ No, If yes, how often?_____

Do you have any jaw joint problems such as soreness, clicking, locking or popping? □ Yes or □ No, If yes, how often? _____

Have you had ***ANY*** injuries or surgeries (minor or severe) to the head, neck, face or teeth? This includes any car accidents, and sports injuries.

□ Yes or □ No, If yes, please explain: _____

_____

Do you have any family history of headaches or migraines? □ Yes or □ No

Do you have frequent headache? □ Yes or □ No, If yes, how often? _____

If yes, do you have any type of aura? □ Yes or □ No, If yes, what is it? _____

Medical History:

(you may leave this section blank if you are a patient of record at our office)

Family Physician: _____ Phone Number: _____

City & State: _____ Date of last physical/check up: _____

Pharmacy Name & Phone Number: _____

Do you or have you ever had any of the following medical conditions:

Heart Murmur	□ Yes or □ No	Cancer/Tumors/Chemotherapy	□ Yes or □ No
Rheumatic/Scarlet Fever	□ Yes or □ No	Leukemia	□ Yes or □ No
Heart Surgery	□ Yes or □ No	Diabetes	□ Yes or □ No
Artificial Heart Valves	□ Yes or □ No	Fainting/Epilepsy/Seizures	□ Yes or □ No
Congenital Heart Defect	□ Yes or □ No	Fever Blisters	□ Yes or □ No
Mitral Valve Prolapse	□ Yes or □ No	Hepatitis (any type)	□ Yes or □ No
Anemia	□ Yes or □ No	Kidney/Liver Problems	□ Yes or □ No
Bleeding Disorders	□ Yes or □ No	Osteoporosis/any bone disorders	□ Yes or □ No
Blood Transfusions	□ Yes or □ No	Asthma/Breathing Difficulty	□ Yes or □ No
Low/High Blood Pressure	□ Yes or □ No	Tuberculosis	□ Yes or □ No
HIV+ or AIDS	□ Yes or □ No	Liver/Kidney/any organ problems	□ Yes or □ No

Are you allergic or have reactions to any of the following?

Aspirin	□ Yes or □ No	Tetracycline	□ Yes or □ No
Codeine	□ Yes or □ No	Intense Light	□ Yes or □ No
Latex	□ Yes or □ No		
Food Dyes	□ Yes or □ No		
Ibuprofen	□ Yes or □ No		
Artificial Flavors	□ Yes or □ No		
Jewelry/ Metals	□ Yes or □ No		
Erythromycin	□ Yes or □ No		
Penicillin	□ Yes or □ No		
Sulfa Drugs	□ Yes or □ No		

Medical History Continued:

(you may leave this section blank if you are a patient of record at our office)

Please list any other medical condition(s) that you have or had:

_____

Are you in good health? □ Yes or □ No

Are you under a physician's care for any reason? □ Yes or □ No, If yes, please explain:

_____

Are you currently taking any pills, medications, herbal, homeopathic or natural remedies? □ Yes or □ No, If yes, please list type and dosage:

_____

Do you smoke, or use any tobacco products? □ Yes or □ No, If yes, what and how often: _____

Do you have any learning disabilities? □ Yes or □ No, If yes, please explain:_____

Female Patients:

Are you or do you think you're pregnant? □ Yes or □ No, If yes, how far along are you? _____

Are you taking any type of birth control? □ Yes or □ No, If yes, what type? _____

Notice of Privacy Practices

This notice describes how health information about your child 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.

This Notice of Privacy Practices describes how we may use and disclose your child's protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this Notice and to maintain the privacy of your child's health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the Notice available upon request.

How We May Use And Disclose Your Child's Protected Health Information

When we give you our Notice of Privacy Practices, you will be asked to sign an Acknowledgement of Receipt. Once you have received our Notice and signed the Acknowledgement, we will use your child's protected health information for treatment, payment, and health care operations. We may use or disclose your child's protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgement of Receipt as soon as is reasonable practical after the delivery of treatment. The following examples show the types of uses and disclosures of your child's protected health information that our office is permitted to make.

Treatment: Your child's protected health information may be used and disclosed by our office and others outside of our office that are involved in their dental care. We will use and disclose your child's protected health information to other dentists and physicians to provide, coordinate, or manage their health care.

Payment: Your child's protected health information may be used and disclosed to pay their health care bills. Your child's protected health information will be used to obtain payment for the services we provide for them. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

HealthCare Operations: We may use or disclose your child's protected health information in order to support the business activities of our practice. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training, and auditing/review activities. For example, we may call your child's name in the waiting room when the doctor is ready for them or send you postcards for appointment reminders. You may contact our Privacy Officer to request that these materials not be sent to you.

Business Associates: We may share your child's protected health information with third party business associates that perform various activities for our practice. Whenever we disclose this protected health information to a business associate, we will have a written contract that will protect the privacy of your child's protected health information.

Written Authorization Is Required For Other Uses Of Your Child's Protected Health Information

Any other uses and disclosures of your child's protected health information will be made only with your written authorization, unless otherwise permitted by law. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your health information as provided for in your authorization.

Use and Disclosure Permitted Without Authorization But With An Opportunity To Object

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend, or any other person you select, your child's protected health information to the extent necessary to help with dental care or payment for the services we have provided. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions, or other similar forms of health information.

Notice of Privacy Practices Continued

Other Disclosures That May Be Made Without Your Authorization

Required By Law: We may use or disclose your child's protected health information when we are required to do so by law.

Abuse or Neglect: We may disclose your child's protected health information to appropriate authorities if we reasonably believe that if your child is a possible victim of abuse, neglect, or domestic violence. We may disclose to authorize official health information required to lawful intelligence, counterintelligence, and other national security activities.

Worker's Compensation & Health Oversight Activities: We may disclose your child's protected health information to comply with Worker's Compensation Laws and to health oversight agencies when conducting investigations or inspections as authorized by law.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliance.

You Have The Following Rights:

Inspect and Copy your Child's Protected Health Information: You have the right to look at or get copies of your child's health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your child's health information. You may obtain access by sending a letter to our Privacy Officer listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee.

Request a Restriction of Your Child's Protected Health Information: You have the right to request that we place additional restrictions on our use or disclosure of your child's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Request Alternative Communications: You have the right to request that we communicate with you about your child's protected health information by alternative means or locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Request an Amendment to Your Child's Health Information: You have the right to request that we amend or correct your child's health information. This request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain circumstances.

Receive an Accounting of Disclosures we Have Made of your Child's Health Information: You have the right to an accounting of disclosures of your child's health information that occurred after August 13, 2008. This accounting will be for purposes other than treatment, payment, or healthcare operations, or disclosures we have made to you, to family members, or friends involved in your child's care. The right to receive this information is subject to some exceptions. If you request this accounting more than one in a 12 month period, we may charge you a reasonable, cost-based fee.

Make a Complaint About our Privacy Practices: If you are concerned that we have violated you or you child's privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom of the page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with the address upon request. We will not retaliate against you for making a complaint or change the way we treat you or your child.

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.

Effective Date: June 2, 2013

Privacy Officer: Kenneth S. Havard, DDS
4507 Williams Drive
Georgetown, TX 78633
(512) 869-4100

Acknowledgment of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Georgetown Family & Orthodontics' Notice of Privacy Practices.

Patient Name: _____

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Staff will complete the section below if patient's signature is NOT obtained.

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our **Notice of Privacy Practices,** but it could not be obtained for the following reason(s):

□ Patient/Parent/Guardian refused to sign

□ Emergency situation kept us from obtaining a signature

□ Language barriers kept us from obtaining a signature

□ Other: _____