WELCOME TO YOUR NEW DENTAL HOME! WE THANK YOU FOR ENTRUSTING US WITH YOUR CHILD'S DENTAL CARE. IN ORDER TO ENHANCE COMMUNICATION AND PROMOTE AN UNDERSTANDING OF HOW OUR OFFICE OPERATES, PLEASE CAREFULLY READ AND INITIAL THE FOLLOWING INFORMATION. BY PROVIDING YOUR SIGNATURE BELOW, YOU INDICATE THAT YOU HAVE READ, FULLY UNDERSTAND, AND AGREE TO OUR OFFICE POLICIES. LET US KNOW IF YOU HAVE ANY QUESTIONS—WE'RE HERE TO HELP.

INSURANCE:

☐ Our office is committed to helping you maximize your insurance benefits. We will gladly accept assignment of benefits (receive payment) from your primary insurance company. We will also submit claims to a secondary insurance policy, should it apply. Insurance policies vary greatly. Because of this, we can estimate your coverage in good faith, but cannot guarantee coverage or payment due to the complexities of insurance contracts. As a courtesy to our patient families, we will bill insurance for covered services and allow the company 45 days to render payment. After 60 days, you will be responsible for the entire balance.

☐ Our office is not contracted or "in-network" with *all* insurance companies, and as such, any fees not covered by your insurance company are solely your responsibility. *We will, however, happily file claims to any insurance company, regardless of network status.* Your estimated patient portion must be paid at the time of service. In the event that we receive payment from your insurance company in an amount greater than initially estimated, we will refund you the difference.

FINANCIAL POLICY:

☐ Please be prepared to pay the patient portion for your child's office visit at the time of service. We accept cash, personal checks, debit, and credit card payments. We can also assist you in obtaining third party financing through DocPay or CareCredit, which offer convenient monthly payment options, no prepayment penalties, and no annual fees.

☐ As mentioned in the insurance policies above, we will submit claims to primary and secondary insurance policies on your behalf. When estimating treatment costs, we will factor in the primary insurance coverage *only* and collect the balance from you on the date of service. *Any benefits due to you from your secondary insurance company will be assigned directly to you*. Should you have a tertiary insurance policy, we will provide you with a detailed receipt of the services rendered so you can submit to a third insurance company.

CHILD CUSTODY:

☐ In cases of divorced parents or joint custody of any kind, the guardian bringing the child to the dental appointment will be deemed the responsible person and must pay at the time of service. Our office will not get involved in disputes related to which parent is financially responsible. While we understand that family relationships can be very delicate, please do not expect us to mediate financial obligations or communications between our office and a patient's guardians.

BILLING:

☐ If a balance remains on your account after insurance has been processed, we will contact you for payment. Once a statement has been sent to you by our office, you will have 30 days to settle the balance without incurring a rebilling fee.

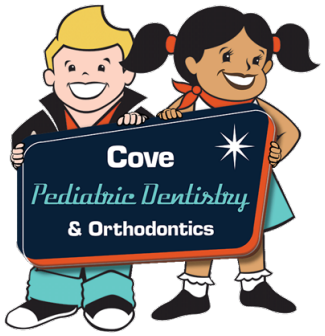
☐ A $50.00 rebilling fee will be assessed to your account should your balance not be cleared in a timely manner (30 days after first billing). After 120 days in which your account balance is not paid in full, your account will be turned over to a collection agency. Please contact our office to discuss additional payment options should the need arise. Additionally, a $50.00 fee will be assessed on all returned checks, and no future checks will be accepted as payment.

BROKEN APPOINTMENTS:

☐ Appointment times are specifically reserved for your child. If you must change your appointment, we request at least 24 hours notice to avoid a $50.00 cancellation fee. In order to best serve all our patients, we may choose to reschedule any patients arriving 10 minutes (or greater) after their appointment start time.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____



NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices 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 outlines 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 reasonably practical after the delivery of treatment. The following examples demonstrate 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. Many of these correspondences are done via email to facilitate timely communications between our office, other providers, and patient guardians.
- **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

- **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 8, 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: April 19, 2018

PRIVACY OFFICER: Kenneth S. Havard, DDS
1009 West Hwy 190 Suite #108
Copperas Cove, Texas
(254) 238-5234

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

I certify that I have received a copy of Cove Pediatric Dentistry & Orthodontics' Notice of Privacy Practices.

PATIENT NAME: _____

PARENT/GUARDIAN NAME: _____

SIGNATURE: _____ DATE: _____

STAFF WILL COMPLETE THE FOLLOWING SECTION ONLY IF A SIGNATURE IS NOT OBTAINED:

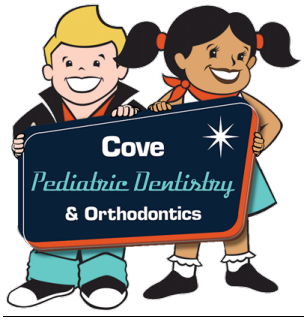
Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason(s):

□ Patient/Parent/Guardian refused to sign

□ Emergency situation kept us from obtaining a signature

□ Language barriers kept us from obtaining a signature

□ Other: _____



PATIENT'S INFORMATION

Last Name: _____ First Name: _____

Preferred Name: _____ Gender: ☐ M ☐ F

Date of Birth: _____ Age: _____

Does the patient attend school?: ☐ Yes ☐ No If yes, where? _____

Child's Physician: _____ Phone #: _____

Physician's Address: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

PARENT OR GUARDIAN INFORMATION

Mother's Full Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Mobile #: _____ Work #: _____

Employer: _____

Email Address: _____

*Please specify relationship to patient if not the mother: _____

Father's Full Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Mobile #: _____ Work #: _____

Employer: _____

*Please specify relationship to patient if not the father: _____

Who does the child live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____

Please provide us with any additional information about your family that you think may be beneficial to our office: _____

_____

_____

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

_____

INSURANCE COVERAGE INFORMATION

Policyholder's Name: _____ Relationship to Patient: _____

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

Policyholder's Employer: _____

Insurance Company Name: _____

Group #: _____ Member #: _____

☐ I certify the insurance information listed above is the patient's primary dental insurance plan

If your child is covered by more than one dental insurance plan, please be aware that there are industry guidelines to determine which plan is considered primary, and which is secondary—this determination is not made by our office *or* you. The subscriber with the birth date earliest in the calendar year most typically holds the primary policy.

We only accept assignment of benefits for primary dental insurance plans. As a courtesy, we will file secondary claims and assign the benefits directly to the policyholder.

APPOINTMENT REMINDERS

We may send text and/or email reminders for your child's dental appointments. Please provide us with the best contact info:

Email: _____ Phone to Text: _____

HOW DID YOU HEAR ABOUT US?

☐ Community Impact

☐ Facebook

☐ GPD&O's staff visited my child's school

☐ Google

☐ Yelp

☐ Drive by/office location

☐ Referral by Friend (please provide a name so we can say, "Thank you!"): _____

☐ Referral by Doctor: _____

☐ Other: _____

HEALTH HISTORY

Check any of the following that pertain to your child:

HEART:

☐ Heart murmur ☐ Mitral valve prolapse ☐ Rheumatic fever ☐ Congenital heart defect
☐ Heart surgery ☐ Low/high blood pressure ☐ Other heart problems: _____

KIDNEY:

☐ Bladder ☐ Urinary problems

LIVER/GI:

☐ Gastritis ☐ Colitis ☐ Diarrhea ☐ Jaundice
☐ Hepatitis ☐ Liver disease ☐ Reflux (GERD) ☐ Stomach/intestinal ulcer

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ENDOCRINE SYSTEM:

☐ Diabetes ☐ Thyroid disease

LUNG/BREATHING:

☐ Hay fever ☐ Sinus trouble ☐ Allergies/hives ☐ Asthma
☐ Chronic cough ☐ Emphysema ☐ TB or Tuberculosis

NEUROLOGICAL:

☐ Fainting ☐ Brain injury ☐ Mental disorder ☐ Developmental delay ☐ Headaches
☐ Speech disorder ☐ Cerebral palsy ☐ Nervous disorder ☐ Seizure disorder/epilepsy

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HEARING/VISION:

☐ Vision problems ☐ Glaucoma ☐ Eye pain ☐ Earaches ☐ Hearing loss

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DERMAL/MUSCULOSKELETAL:

☐ Rash ☐ Allergy to latex ☐ Arthritis ☐ Fever blisters ☐ Ulcers

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SLEEP RELATED BREATHING PROBLEMS:

☐ Snoring ☐ Restless sleeper ☐ Frequently tired ☐ Morning headaches
☐ Falling asleep at school ☐ Trouble concentrating at school

Does the patient have any disease, condition, syndrome or other health problem not listed above? ☐ Yes ☐ No

*If yes, please list:*_____

Is the patient in overall good health? ☐ Yes ☐ No

Is he/she up to date with immunizations? ☐ Yes ☐ No *Notes:* _____

Has he/she been hospitalized since birth? ☐ Yes ☐ No *If yes, what for:* _____

HEALTHY HISTORY, CONTINUED

Is the patient currently taking medication? (prescription *or* over the counter): ☐ Yes ☐ No

If yes, please list: _____

Is the patient allergic to any medications? ☐ Yes ☐ No *If yes, please list:* _____

Is he/she presently receiving medical treatment? ☐ Yes ☐ No *If yes, what for?:* _____

When was the child's last physical exam? _____

Describe your child's personality and interaction with parent/guardian: _____

_____

Describe your child's personality as it pertains to a healthcare environment: _____

_____

DENTAL HISTORY

Date of patient's last dental visit: _____ Name of dentist: _____

Has patient had any unhappy dental experiences? ☐ Yes ☐ No

If yes, please explain: _____

Does the patient have a toothache? ☐ Yes ☐ No *If yes, please explain:* _____

Does the patient have any jaw pain? ☐ Yes ☐ No *If yes, please explain:* _____

At what age did the patient discontinue the bottle or nursing? _____ ☐ *check if still nursing*

Does patient have any mouth habits (thumb or finger sucking, pacifier, grinding, etc.)? ☐ Yes or ☐ No

If yes, please explain: _____

Does the patient brush daily? ☐ Yes ☐ No *If yes, how often?* _____
Does the patient use floss? ☐ Yes ☐ No *If yes, how often?* _____

Does an adult assist with home dental care? ☐ Yes ☐ No *If yes, who:* _____

What type of water is typically used for brushing, cooking, drinking? ☐ City Water ☐ Well Water ☐ Bottled Water

ORTHODONTIC CONCERNS

Are you concerned about the straightness and/or appearance of your child's teeth? ☐ Yes ☐ No

Have you ever considered orthodontic treatment? ☐ Yes ☐ No

Are you interested in learning more about the orthodontic treatment options we offer? ☐ Yes ☐ No

SIGNATURE: _____ **DATE:** _____