Patient Information

Patient Name: _____ *Date:* _____

☐ *Male* ☐ *Female* ☐ *Married* ☐*Single* ☐ *Child* ☐ *Other* _____

Social Security #: _____ *Birth Date:* _____

Phone (Home): _____ *(Work):* _____ *Ext:* _____*Best time to call:* _____

Phone (Cell): _____ *E-Mail Address:* _____

Address: _____ *Apt:* _____

Spouse or Responsible Party Information

The Following is for: ☐ *Patient's spouse* ☐ *The person responsible for payment*

Name: _____

☐*Male* ☐*Female* ☐*Married* ☐ *Single* ☐ *Child* ☐ *Other* _____

Social Security #: _____ *Birth Date:* _____

Phone: (Home): _____*(Work):* _____ *Best time to call:* _____

Address: _____*Apt:* _____

City: _____ *State:* _____ *Zip Code:* _____

Employment Information

The following is for: ☐ *The Patient* ☐*The person responsible for payment*

Employer Name: _____ *Occupation:* _____

Address: _____*City:*_____ *St:* _____ *Zip:*_____

Insurance Information

Primary

*Name of insured:*_____*Is the insured a patient:* ☐ *Yes* ☐ *No*

Insured's Birth Date: _____ *ID#:* _____ *Group #:* _____

Insured's Address: _____ _____

City: _____ *State:* _____ *Zip Code:* _____

Insured's Employer's name: _____

Patient's relationship to the insured: ☐*Self* ☐*Spouse* ☐*Child* ☐ *Other:* _____

Insurance Plan Name and Address: _____

Insurance Phone Number: _____

Secondary

*Name of insured:*_____*Is the insured a patient:* ☐ *Yes* ☐ *No*

Insured's Birth Date: _____ *ID#:* _____ *Group #:* _____

Insured's Address: _____ _____

City: _____ *State:* _____ *Zip Code:* _____

Insured's Employer's name: _____

Patient's relationship to the insured: ☐*Self* ☐*Spouse* ☐*Child* ☐ *Other:* _____

Insurance Plan Name and Address: _____

Insurance Phone Number: _____

Referral Information

Whom may we thank for referring you to our practice: ☐ Another patient, friend ☐ Another patient, family

☐ Dental office ☐ Yellow pages ☐ Newspaper ☐ Radio ☐ Work ☐ Other: _____

Name of person or office that referred you to our practice: _____

Health Information

Date of last dental visit: _____Reason for this visit: _____

Have you ever had any of the following? Please check all that apply:

- ☐ AIDS
- ☐ Allergies_____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Auto Immune disease _____
- ☐ Blood disease
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hashimoto's
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ HIV
- ☐ High blood pressure
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Latex allergy
- ☐ Liver disease
- ☐ Mental disorder
- ☐ Nervous disorder
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation treatment
- ☐ Respiratory problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus problems
- ☐ Stomach problems
- ☐ Stroke
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Codeine allergy
- ☐ Penicillin allergy
- ☐ Other: _____ _____ _____

Medications Taking:

_____ _____ _____ _____ _____

- Have you ever had any complications follow dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician: ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____Phone #:_____
- Do you have any health problems that need further clarification? Yes ☐ No ☐
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have any change in my health, I will inform the doctors at my next appointment, without fail.

Patient signature:_____ Date: _____

Consent for Service

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that before treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by and insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Legacy Family Dental

CONSENT AND AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent and Agreement, please initial where indicated and print and sign your name below to accept the terms of this agreement.

1.) **Consent to Treat:** As a consenting adult, I agree to permit the dental staff at Dr. McConnell's office to provide dental care to myself, my child, or patient representative as applicable.

Initials: _____

2.) **Drugs and Medications:** I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. (severe allergic reaction)

Initials: _____

3.) **Follow-Up Appointments:** I understand that by accepting treatment at Legacy Family Dental, I also consent to future follow-up appointments for the purpose of assessing the outcome of dental treatment provided to me as the patient.

Initials: _____

4.) **Changes in Treatment Plan:** I understand that during the treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations, the most common being root canal therapy routine restorative procedures. I give my permission to Dr. McConnell to make any/all changes.

Initials: _____

5.) **No-show/Cancellation Policy:** Our goal is to provide high quality care to our patients and in fairness to other patients and the doctor, we require at least 24 hours' notice when canceling an appointment. **You may be charged $25 for every 30 minutes that is scheduled for missed appointments without 24 hours' notification, which will be due and payable from you.** The practice reserves the right to dismiss patients with excessive cancelled appointments.

Initials: _____

6.) **Right to Discontinue Treatment:** Our office has the right to discontinue treatment for any appropriate reason, such as, excessive cancellations. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. A letter will be sent informing the patient of patient's representative that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of Dr. Todd McConnell, D.D.S. Records and x-rays will be sent upon written request.

Initials: _____

7.) **Notice of Privacy Policies:** Dr. McConnell may release information to other entities or health care providers for treatment, payment of services, and for health care operations as described in the "Notice of Privacy Policies". We have prepared this detailed document to help you better understand our policies in regard to the use and disclosure of your personal health information. I have been given the opportunity to review and receive a copy of the Notice of Privacy Practices.

Initials: _____ **Printed Name:** _____

Signature: _____ **Date:** _____

Legacy Family Dental

OFFICE FINANCIAL POLICY

If you have dental insurance, it is important to understand your policy so you can receive the maximum benefits you are entitled to. To save time and confusion, and for us to better serve you, we strongly recommend that you get an explanation of benefits on your policy from either your employer or the insurance company itself. Please keep in mind that the policy you carry is a contract between you and the insurance company. As a courtesy to our patients, we will bill your insurance for all services done in our office. However, please be aware that most insurance plans only cover a portion of dental fees and that you may be responsible for payment of any of the following:

- Annual deductible: This is the amount of money that must be paid before treatment begins
- Fees above your policy maximum: This is the amount you are allowed in a specified amount of time.
- Exclusions and Waiting Periods: Most insurance plans have some treatments that are not covered at all or there is a waiting period in place before the insurance company would pay for the service.

If you can provide accurate insurance information to our office, and with verification of your coverage, we will ***estimate*** the cost of your treatment at the time services are rendered. You will be responsible for your ***estimated*** portion the day that treatment is provided. ***The amount we estimate is not a guarantee of what your insurance will pay. You could owe more than your original payment or you could be refunded money if your insurance plan pays more than expected***.

It is possible that you still may have to pay a patient portion. This all depends on the level of benefits you have purchased from the insurance company. If you cannot provide accurate insurance information by your first visit, we will ask you to pay in full for services that are provided that day. Until we have received the information needed to bill your insurance, it will become your responsibility to collect any monies from them. We will provide a statement for you that will describe the services that occurred that day.

You will receive a monthly statement from us whenever there is a balance on your account. If your insurance company has not paid your claim(s) within 45 days, it is your responsibility to find out why. **You are responsible for any balances on the account not paid by insurance. After 90 days accounts are considered overdue regardless of insurance company delays. Overdue accounts will be subject to a monthly late fee or turned over to a collection agency with a fifty percent fee added to the account balance.**

Please feel free to call our office if you have any questions or concerns regarding your monthly statement.

If you do not have insurance coverage, payment in full will be due the day services are rendered. We accept many forms of payment including cash, checks, Visa, MasterCard, Discover, American Express and the Care Credit Program. If you are interested in learning more about the Care Credit Program, please ask our front office staff.

By signing below, I am indicating that I have read and understand the terms of the Consent and Agreement for Treatment and Office Financial Policy. I am either the patient or have the authority to give consent for the patient. I give consent to Dr. McConnell to perform necessary or appropriate tasks for proper dental and physical examination, diagnosis, and treatment, including local anesthesia.

_____ _____

Patient or Patient Representative Signature Date

_____ _____

If Patient Representative, Relationship to Patient Witness

Legacy Family Dental

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your 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 protected health information, and of other important matters about your 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 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:

Contact Person: Raida

Telephone: (972) 491-2136 Fax: (972) 491-0899

E-mail: As Found in web site www.legacyfamilydental.com

Address: 3105 Legacy Drive Ste. B Plano TX 75023

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

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 protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

R. Todd McConnell DDS PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your 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 practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.15__ for each page, $20.xx___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative 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.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: (972) 491-2136 Fax: (972) 491-0899

Address: 3105 Legacy Drive Ste. B Plano , TX 75023

Legacy Family Dental
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but 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)

_____

_____

_____