



DENTAL HEALTH ASSOCIATES

Dennis Calvano, D.M.D & Daniel B. La Grua, D.M.D

PATIENT INFORMATION—CHILD

First Name _____ Middle Name _____ Last Name _____

Nickname _____ Birth Date _____ Social Security # _____ Gender _____

Home Address _____ City _____ State/Zip _____

Mother's Name _____ Birth Date _____ Social Security # _____

Home Telephone # _____ Work Telephone # _____ Cell Telephone _____

Father's Name _____ Birth Date _____ Social Security # _____

Home Telephone # _____ Work Telephone # _____ Cell Telephone _____

Whom may we thank for your referral? () www.cfdentistry.com () Phone Book () Verizon () Yellowbook () Ntelos
() Family/Friend Name: _____ () Another Office Name: _____

Responsible Party's E-mail address: _____

How would you prefer that we confirm your child's appointments? () Home phone () Work phone
() Cell Phone () E-mail message

DENTAL INSURANCE INFORMATION

Policyholder's Name _____ Policyholder's Birth Date _____

Relationship of policyholder to you: () Spouse () Parent () Other _____

Dental insurance company _____

**YOU MUST PRESENT AN INSURANCE CARD FOR PHOTOCOPY OR AN EMPLOYEE
INSURANCE CLAIM FORM AT YOUR INITIAL VISIT OR ANY TIME CHANGES
TAKE PLACE IN YOUR COVERAGE**

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Calvano/ La Grua for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependants, whether or not paid by insurance. I authorize the above doctor(s) and /or any provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and healthcare operations. I authorize the use of this signature (at the end of this form) on all insurance submissions.

FINANCIAL POLICY

Payment of fees and co-payments/deductibles are expected at the time of service. We will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid in full. In the event that my account must be turned over for outside collection, I agree to pay all costs related to collection, to include any court costs and attorney fees that may accrue, and an office collection fee of \$ 35.00. I understand that any account information necessary for collection will be released to a collection company that may affect my credit report. I also understand that there is a 1.5 % finance charge for any/all balances that I am billed for and a \$35.00 returned check fee for any check returned for insufficient funds.

OFFICE POLICY

Appointments: a minimum charge may be made for missed or cancelled appointments without prior notification of 24 hours. I understand that failure to give a 24 hour notice that I cannot keep a reserved appointment will result in a missed appointment fee of \$ 50.00 and, should this happen three times, will result in dismissal from the practice. Our office reserves the right to refuse appointments for late cancellations as well as failure to attend. PLEASE REMEMBER THAT ONCE AN APPOINTMENT IS MADE, THIS TIME IS RESERVED ESPECIALLY FOR YOU

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. 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 and or to continue treating you if you revoke this Consent

I, THE UNDERSIGNED, UNDERSTAND AND AGREE TO THE POLICIES STATED ABOVE. I CERTIFY THAT THE INFORMATION ON THIS FORM IS ACCURATE, TO THE BEST OF MY KNOWLEDGE.

Date

Signature (Guardian if under 18 years of age)

1557 COMMERCE ROAD, SUITE 204, VERONA VIRGINIA 24482

PHONE: 540.248.2500 / FAX: 540.248.2526

cfcd@comcast.net

www.cfcdentistry.com

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 April 14, 2003, 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 DISCLOSURE

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

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

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

Health Care Operations: We may use and disclose your health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your health information as necessary to contact you by telephone, voicemail, mail or e-mail to confirm your appointments.

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 care 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; 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.

Family and Friends: We must disclose your health information to you, the patient, 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

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incapacity of 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 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.

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

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonable 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 serious threat to your health or safety or the health or safety of others.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. (You must make your request in writing to obtain access of your health information.) You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you a nominal fee for expenses, such as multiple copies, postage, etc.

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.

Restrictions: 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 the case of an emergency).

Alternative Communication: You have the right to request (request must be in writing) that we communicate with you about your health information by alternative means or locations. Your request must specify the alternate means or location, and provide satisfactory explanation of how payments will be handled under such alternative means or locations.

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 use and disclosure of your health information, 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.

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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 your name (and child's name, if he or she is the patient)

Your signature

Date

FOR OFFICE USE ONLY

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

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CONSENT FOR PERSONAL HEALTH INFORMATION

By signing below, I acknowledge that I have received and read the *Notice Of Privacy Practices* and request that the following do not have access to my Personal Health Information. (PHI) or phone numbers

Print Patient Name

Date of Birth

Name

Relationship

Name

Relationship

Name

Relationship

Patient Signature

Date

This acknowledgement page will be retained in the patient record.

I Hereby VOID the above request.

Patient Name/Date