Name_____Birthdate:_____

Address:_____City/State/Zip_____

Home Phone:_____ Work_____ Cell_____

E-mail _____

Social Security # _____ Sex: M F Are you Married Y N

Place of Employment _____

Name of person responsible for payment: _____

Address: _____Phone: _____

Method of payment: Cash Check MC/Visa/Discover

DO YOU HAVE DENTAL INSURANCE: Y N (If yes, complete back side)

Whom may we thank for referring you: _____

Has any member of your family been here: _____

GENERAL HEALTH:

| | | |
|---|---|---|
| Y | N | 1. Have you had any illnesses requiring a physicians care during the last year? |
| Y | N | 2. Do you presently take any medication? _____ |
| Y | N | 3. Have you ever taken cortisone? If so, when _____ |
| Y | N | 4. Has a Dr. ever told you that you have heart trouble? Type: _____ |
| Y | N | 5. Has a Dr. ever told you that you have had rheumatic fever or a heart murmur? |
| Y | N | 6. Do you wear a pacemaker? |
| Y | N | 7. Have you ever had Hepatitis (A or B or C) |
| Y | N | 8. Have you been tested for AID/HIV? Date of test: _____Pos. Neg. |
| Y | N | 9. Do you have abnormal blood pressure? Low High |
| Y | N | 10. Do you ever have fainting or dizzy spells? |
| Y | N | 11. Have you ever had any convulsions or seizures (epilepsy)? |
| Y | N | 12. Have you ever had diabetes, kidney or liver disease? (circle) |
| Y | N | 13. Have you ever had any serious illnesses or operations? _____ |
| Y | N | 14. Did you ever have tuberculosis? |
| Y | N | 15. Do you have any allergies or asthma? _____ |
| Y | N | 16. Are you allergic to any medication? _____ |
| Y | N | 17. Women: Are you pregnant? Due Date: _____ |

DENTAL HISTORY:

| | | |
|---|---|---|
| Y | N | 1. Are you in pain? |
| Y | N | 2. Have you visited a dentist during the past year? |
| Y | N | 3. Have you ever had abnormal bleeding from a cut or tooth ext? |
| Y | N | 4. Have you ever experienced any reaction to dental anesthetics? |
| Y | N | 5. Did you ever have a jaw or mouth injury? |
| Y | N | 6. Do you know of any growth or sores in your mouth? |
| Y | N | 7. Do your gums bleed? |
| Y | N | 8. Are any of your teeth loose? |
| Y | N | 9. Do you notice if you have bad breath? |
| Y | N | 10. Is there something about your teeth that you do not like or concerns you? |

Explain _____

In case of emergency notify: _____Phone: _____

**The patient (guardian) agrees to be and hereby is fully responsible for total payment of procedures performed in this office including any amount which are not covered by any dental insurance or prepayment program that the patient may have. Accounts past due more than 60 days are assessed a 2% finance charge.**

**Signature** _____ **Date:** _____

**As a courtesy to you we will submit insurance claims and accept assignment of benefit payments from most insurance companies. However, your dental insurance is your responsibility. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient / guardian, are responsible for the total treatment fee.**

## REFERRALS

Whom may we thank for referring you: _____

Has any member of your family been here: _____

## PAYMENT

Method of Payment: Visa MC Discover (circle one)

INSURANCE INFORMATION:

1. Patient Name: _____
2. Patient Relationship to Insured: _____
3. If full time student, school & city _____
4. Insured's name and address: _____

   _____
5. Insured"s SSN: _____ Date of Birth: _____
6. Employer and address: _____
7. Insurance Company: _____ Group #: _____

   Address: _____ Tel. #: _____

IF YOU HAVE DUAL INSURANCE, PLEASE CONTINUE:

1. Insured"s full name: _____

   Address: _____ Tel. #: _____
2. Patient's Relationship to Insured: _____
3. Insured's SSN: _____ Date of Birth: _____
4. Employer: _____

   Address: _____
5. Insurance Company: _____ Group # _____

   Address: _____ Tel. #: _____

I authorize release of any information relating to my insurance claims. I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of benefits to be paid directly to Stephen P. Mattingly, DMD.

_____ Date: _____

Signature

# Dr. Stephen P. Mattingly, D.M.D.

## 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/13 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

---

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and

coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

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

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

## Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

## Your Health Information Rights

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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 information that we maintain on paper, we may provide photocopies. If you request information that we maintain

electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach**. You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

## 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 if 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.

Our Privacy Official: Jamie Josselyn
Telephone: 859-623-0222 Fax: 859-624-3440

Address: 805 Eastern By-pass, Suite 4, Richmond, KY 40475

E-mail: stevemattingly@richm.twcbc.com

## Stephen P. Mattingly, D.M.D.

{

* You May Refuse to Sign This Acknowledgment*

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

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)

_____

_____

_____

**Authorization Form for Use or Disclosure of Patient Information**

This form illustrates how our dental practice obtains and documents authorization for a use or disclosure of patient information that is not permitted or required by HIPAA.

Patient Name:_____

Patient's Date of Birth:_____ Patient's Chart No.: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:

_____

_____

Purpose(s) of this use or disclosure:

_____

**[If the patient or the patient's personal representative is requesting the use or disclosure, you may write "at the request of the individual" for the purpose.]**

I authorize the following person(s) to make this use or disclosure:

_____

_____

The following person(s) may receive this patient information:

_____

**[If this authorization is required for a use or disclosure of patient information for a subsidized marketing communication, add "I understand that the dental practice will receive financial remuneration for making this marketing communication."]**

**[If this authorization is required for a sale of patient information, add "I understand that this disclosure will result in remuneration to the dental practice."]**

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at _____. **[Insert address of the Privacy Official (or other person at the dental office responsible for patient authorizations). If the description of how to revoke an authorization is in the Notice of Privacy Practice, replace the first sentence of this paragraph with "I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing."]** If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. **[If an exception to the prohibition on conditioning authorizations applies, delete this sentence and insert a description of the consequences to the patient of a refusal to sign the authorization.]**

This authorization expires on the following date, or when the following event occurs:

_____

**[Expiration events must relate to the patient or to the purpose of the use or disclosure. If the authorization is for research, the expiration may state "end of the research study," "none," or similar language.]**

**Signature of Patient or Patient's Personal Representative:**

_____Date_____

If Personal Representative:

Print Name:_____

Signature:_____Relationship to Patient:_____

For office use only: Copy of signed authorization provided to the individual:
Date:_____
Initials:_____