NOTICE OF PRIVACY PRACTICES

STEVE CHAPMAN ORTHODONTICS

PRIVACY AND SECURITY

Our Practice's privacy and security practices are derived from the Department of Health and Human Services regulations, which were implemented in 2003 and include the omnibus updates that went into effect as of September 18, 2013. We are required to keep your personal and health information secure and confidential at all times. A copy of our privacy practices is available at our reception desk.

YOUR PERSONAL AND HEALTH INFORMATION WILL NEVER BE USED NOR DISCLOSED EXCEPT FOR THE PROVISIONS LISTED IN THIS NOTICE, EXEPT WITH YOUR WRITTEN PERMISSION.

You may request that we not use nor disclose some or all of your information as described in this notice. This request must be in writing and we will promptly advise you if we are able to fulfill your request.

We are allowed to use or disclose you personal information in normal and customary manners such as with other Healthcare Providers involved with your treatment. We may also use and disclose your information for payment services with insurance companies to include but not limited to reports on your treatment and progress.

We may use your information with our Business Associates such as Labs and billing companies, all of which we have a written contract to protect and keep your private information secure and confidential.

We may contact you or your assigned designee about treatment follow up, account information, newsletters or other information by phone, text, email or mail. If you do not answer the phone, we may leave a message for you on your answering machine, voicemail or whomever answers the phone number you provide us with. In an emergency, we may disclose your health information with your family, a designee or other persons responsible for your care. We will release some or all of your personal and health information when required by law.

PATIENT RIGHTS

You have the right to know of any use or disclosure of your information other than the normal and customary, should they occur.

You have the right to receive a copy of this notice and it is always available at our reception desk.

You have the right to review and obtain a copy of your health information, with few exceptions. If you would like a copy of this information, please submit a request in in writing for the specific information you would like. If you prefer a digital copy and copy and it is available, we will try to accommodate your request. We may charge a reasonable fee to cover the cost.

You have the right to have a copy of your records transferred to another practice. Notify us in writing of where you would like this information sent.

You have the right to request, in writing, an amendment or change to your health information or for a statement to be added to your file. We may or may not be able to make a change to your request but will include your statement in your records. If we agree to an amendment or change, we will not remove nor alter earlier documents but will add the new information.

You have the right to know if our privacy and security measures or systems are ever breached and be notified.

If we change any of the details of this Notice, we will post the new Notice prominently in our practice location and on our website with a copy available upon request.

Consent for Use and Disclosure of Health Information and Release Form

PATIENT INFORMATION

Patient's Name _____ DOB: _____/_____/_____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email _____

Our Practice has always safeguarded and protected our valued patient's personal and health information. These safeguards meet or exceed the 2003 **H.I.P.A.A.** *(Health Insurance Portability and Accountability Act), under the Department of Health and Human Services* requirements to include the September 2013 "*Omnibus"* updated Privacy regulations. Our Practice Privacy policies, in accordance, allows us to use your personal information for "Normal and Customary" services when required communication within the Healthcare profession, both clinical and administrative to include but not limited to: Consultations with another Healthcare professional such as your medical doctor or another dental specialist about your treatment or progress, assisting with patient insurance, appointment reminders, account financial information and laboratory cases.

□ ***Request For Exemption(s)***- Mark this box if you wish for any of your information NOT to be used for normal and customary practices within the Healthcare Profession, specifically write your request for exemption(s) or limitations(s) below. *Example: No calls to work phone.*

***Practice Use Only**: Exemption(s) declined, Patient informed. Signature/Date:_____*

Who May We Release Information to: Please specify anyone you authorize our Practice to release information and what type on information we may give out, if requested and approved, about you, your treatment, progress or account. Usually this is a spouse or significant other, Parent or guardian, Grandparents, adult children or whomever you choose to authorize our Practice and our Healthcare Associates to release information to.

PLEASE PRINT COMPLETE NAME(S) AND LEGAL RELATIONSHIP TO PATIENT.

_____ _____

Complete Name Relationship Date ***Complete Name*** Relationship Date

Type of Information authorized to release: Type of Information authorized to release:

□ **NO RESTRICTIONS FOR THIS INDIVIDUAL** □ **NO RESTRICTIONS FOR THIS INDIVIDUAL**

□*Treatment/Condition* □*Financial/Administration* □*Treatment/Condition* □*Financial/Administration*

_____ _____

Complete Name Relationship Date ***Complete Name*** Relationship Date

Type of Information authorized to release: Type of Information authorized to release:

□ **NO RESTRICTIONS FOR THIS INDIVIDUAL** □ **NO RESTRICTIONS FOR THIS INDIVIDUAL**

□*Treatment/Condition* □*Financial/Administration* □*Treatment/Condition* □*Financial/Administration*

I have read, reviewed and considered the contents of this Consent form and was given a copy of the Practice's "Notice of Privacy Practices." I understand, that by signing this Consent form, I am giving my legal consent for your disclosure and use of mine and/or my dependents *(minor Child or other person(s) whom I am the legal guardian of)* protected Private personal and health information in any form deemed needed in the Practice's professional judgement and in accordance with our normal and customary Privacy and Security practices. You have the legal right to amend or revoke this consent given at any time by providing us written notice.

_____ _____

Signature (Adult) Date ***Signature (Adult)*** Date

□ Patient □ Parent □ Legal Guardian □ Other *(Specify)* □ Patient □ Parent □ Legal Guardian □ Other *(Specify)*

Dr. Steve Chapman
Orthodontics

3520 St. Johns Ave.
Palatka, Florida 32177
386-328-8351

WELCOME

We would like to welcome you to our office.
In an effort to provide the best service possible,
We ask you to fill out this form as completely
as possible. Thank you for your cooperation.

ABOUT YOU

Patient's Name: _____ ☐ Male ☐ Female
(FIRST / MIDDLE / LAST)

What do you prefer to be called?: _____ DOB: _____ Age: _____ SS#: _____

Mailing Address: _____
(CITY / STATE / ZIP)

Cell Phone: ( ) _____ Home Phone: ( ) _____

Work Phone: ( ) _____ Ext: _____ Do you have children? ☐ Yes ☐ No How many? _____

Employer: _____ How Long? _____ Occupation: _____

Employer's Address: _____

Status: ☐ Single ☐ Married ☐ Domestic ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Company Address: _____ Group or Plan: _____

Insured's Name: _____ Insured's Birthday: _____

Relationship: _____ Insured's SS#: _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Company Address: _____ Group or Plan: _____

Insured's Name: _____ Insured's Birthday: _____

Relationship: _____ Insured's SS#: _____

Insured's Employer: _____ Employer's Address: _____

IN EVENT OF EMERGENCY

Whom should we contact?: _____ Relation: _____

Cell Phone: ( ) _____ Who is your Medical Doctor?: _____

Doctor's Phone: ( ) _____

REFERRAL SOURCE

Whom may we thank for referring you ? ☐ Dentist ☐ Patient ☐ Internet Search ☐ Insurance ☐ Radio ☐ Sports ☐ Other (specify)

Name of Referrer: _____

_____ INITIALS

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please continue on back

DENTAL/MEDICAL HISTORY

What is your main reason for visiting the orthodontist today? _____

General Dentist: _____ Phone: _____

Address: _____ Last Visit: _____

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Have there been injuries to the face, mouth or chin? ☐ Yes ☐ No

Physician Name: _____ Phone: _____ Last Visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription drugs? ☐ Yes ☐ No Drug and Dose: _____

Are you currently under the care of a doctor? ☐ Yes ☐ No Explain: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

☐Y ☐N Prosthesis	☐Y ☐N Tuberculosis	☐Y ☐N Convulsions/Epilepsy	☐Y ☐N Severe/Freq Headaches
☐Y ☐N Heart Attack	☐Y ☐N Shingles	☐Y ☐N Abnormal Bleeding	☐Y ☐N Hi/Lo Blood Pressure
☐Y ☐N Cancer	☐Y ☐N Fever Blister	☐Y ☐N Artificial Valves	☐Y ☐N Chewing/Eating Problems
☐Y ☐N Diabetes	☐Y ☐N Finger/Thumb Sucking	☐Y ☐N Heart Surgery/Pacemaker	☐Y ☐N Blood Transfusion
☐Y ☐N Grinding teeth	☐Y ☐N Speech Problems	☐Y ☐N Pregnant	☐Y ☐N Anemia/Radiation Therapy
☐Y ☐N HIV+/AIDS	☐Y ☐N Heart Murmur	☐Y ☐N Kidney/Liver Problems	☐Y ☐N Glaucoma
☐Y ☐N Hemophilia	☐Y ☐N Tongue Thrust	☐Y ☐N Mitral Valve Prolapse	☐Y ☐N Difficulty Breathing?
☐Y ☐N Asthma	☐Y ☐N Sinus Problems	☐Y ☐N Artificial Bones/Joints	☐Y ☐N Other: _____
☐Y ☐N Hepatitis	☐Y ☐N Congenital Heart Defect		

Are you allergic to any of the following?: ☐Y ☐N Aspirin ☐Y ☐N Dental Anesthetics ☐Y ☐N Tetracycline ☐Y ☐N Other: _____

☐Y ☐N Antibiotics ☐Y ☐N Latex ☐Y ☐N Penicillin

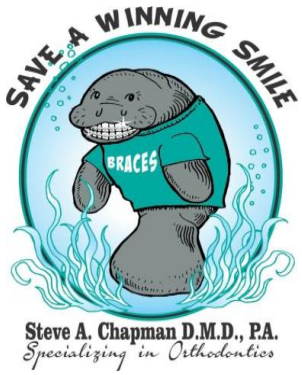
CONSENT TO X-RAYS AND EXAMS

It is necessary to take diagnostic x-rays in order to determine an appropriate treatment plan and patient diagnosis. Your signature below authorizes Chapman Orthodontics to take these necessary x-rays.

I understand the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature of Patient/Legal Guardian Date



Standard Artist Release For The Office Of Dr. Steve Chapman D.M.D., P.A.

I hereby authorize the office of Dr. Steve Chapman D.M.D.,PA the right (all rights) to any picture, photograph, video, or similar data used for (or related to) a orthodontic purpose. I also authorize said producer, without limitation the right to reproduce, copy, cable-cast, exhibit/publish, display on any social media site, or distribute and such picture. This being said I expressly waive any rights or claims I may have against your office and/ or any of its affiliates, subsidiaries, or assignees except as outlined in the contract.

_____ _____

Print Parent/Guardian Name Signature Date

_____ _____

Print Patient Name Signature Date