



PATIENT INFORMATION

FIRST: _____ LAST: _____ NICKNAME: _____ SEX: M F
 ADDRESS: _____ DENTIST: _____
 CITY: _____ STATE: _____ ZIP: _____ REFERRED BY _____
 HM. PH: _____ SSN: _____ DOB: _____ AGE: _____
 BEST CONTACT # FOR AUTOMATED CONFIRMATION CALLS: _____ HM, CELL, WORK, OTHER
 (Circle One)

PARENT/GUARDIAN INFORMATION (Complete for minor patients under the age of 18)

FIRST: _____ LAST: _____ NICKNAME: _____
 SSN: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____
 DO YOU HAVE LEGAL CUSTODY OF PATIENT? Yes/No If no, please indicate who is legal custodian: _____
Circle One
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 HM.PH: _____ WORK PH: _____ CELL PH : _____
 SPOUSE'S NAME: _____ SPOUSE'S RELATIONSHIP TO PATIENT: _____

MEDICAL HISTORY OF PATIENT

Y N

Has there been any history of joint swelling, heart trouble, asthma, TB, Aids, kidney or liver ailment, epilepsy, Rheumatic fever or other major illness? _____

Does the patient bleed easily or is bleeding hard to stop? _____

Is there a tendency to faint or become dizzy? _____

Are there any drug allergies? (sulphur, penicillin, Novocain, etc.) _____

Have tonsils or adenoids been removed? _____

Are medicines now being taken? List: _____

Is the patient under the care of a physician at present? _____

DENTAL HISTORY OF PATIENT

Were any teeth removed by extractions? _____

Was it suggested that a space maintainer be placed? _____

Is the patient a mouth breather? _____

Were there habits that might have caused the teeth to move? _____

Has an orthodontist been consulted previously? _____

Have we treated any other family members? Who _____

What would you like orthodontic treatment to accomplish?: _____

_____ **Payment is due upon receipt when services are rendered unless prior arrangements have been made. In the event an account is referred for collections, or suit is instituted, I agree to pay all expenses of collection, including but not limited to, attorney's fees of 40% and all court costs. Interest will accrue at the rate of 24% per annum on any amount not paid within thirty (30) days of the date services were rendered. I authorize a credit report to be obtained in the event of collection procedures. Venue for any legal action will be exclusive in the City of Virginia Beach, Virginia. I have read and understand the above statement.**

Signature of financially responsible party (Guarantor): _____ Date _____

Printed Name: _____ Guarantor SSN: _____ Guarantor DOB: _____

APPOINTMENT GUIDELINES

Our goal is to provide the highest quality care to our patients. This includes being considerate of your time. We make every effort to be on time to see you when you come in for your scheduled appointment. Most of our parents work, as do our adult patients, and all children attend school. **IT IS UNAVOIDABLE THAT SCHOOL OR WORK BE MISSED.** We reserve short appointments for the afternoons in order to reduce the number of times school or work will have to be missed. All appointments longer than 25 minutes are scheduled earlier in the day in order to allow for more appointments after school. Please understand that this policy is for your benefit, not ours. If we scheduled long appointments after school, approximately 80% of appointments would be during school hours. By reserving morning and afternoons for short appointments, less than 50% of your appointments will have to be in the middle of the day.

Patients arriving after their scheduled appointment will be rescheduled. It will be unfair for us to use your scheduled time to treat a patient who comes in late for their appointment.

If you reschedule your appointment please do so as soon as possible. The closer your call is to the actual appointment, the longer it will take to get back in. This is because we work on a six week schedule rotation and all appointments may be booked. As a courtesy to you, we have installed an automated calling system that will remind you of you appointment 48 hours in advance. We will make every effort to remind you; however, this is a courtesy and it is the patient's responsibility to know their next appointment time. Cancellations may be made on our voice message system. We require at least 24 hours notice to change an appointment. If you have to reschedule your appointment without 24 hours notice or miss the appointment entirely, a \$50 charge will be incurred. In addition, all missed appointments will be rescheduled between the hours of 9:00 a.m. and 12:00 p.m.

Thank you very much for your understanding.

I have read and understand the aforementioned.

Parent/Patient Signature

Date

Carl P. Roy D.D.S., M.S., P.L.C.
2100 Lynnhaven Parkway Ste 200 Virginia Beach, VA 23456 757-471-2900
684B Battlefield Blvd. N Chesapeake, VA 23320 757-549-1115

Dental Insurance Information

This form is for DENTAL coverage only. The information you provide will be used to verify your orthodontic benefit. As a courtesy, we are happy to file an orthodontic insurance claim on your behalf once active treatment is initiated.

We are unable to verify and/or file your claim if all information requested is not provided, so please complete ALL information requested.

Current Date: _____

Patient Name: _____
Last First (Nickname)

Patient's DOB: _____ Patient's SSN: _____

******Optima is for medical coverage only. Please provide dental carrier info.******

Primary Insurance

Primary Subscriber's Full Name: _____
Last First (Nickname)

Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's relationship to patient: (circle one)
Self/Spouse/Father/Mother/Step-father/Step-mother/Grandfather/Grandmother
Other (if other, indicate relationship): _____

Subscriber's Home Address: _____ City _____ State _____ Zip _____
(If different than patient)

Insurance Carrier Name: _____ Ins. Carrier Phone # _____
Please indicate State if applicable (i.e. Delta VA, BCBS AL, etc)

Subscriber ID # (if different than SSN): _____ Group #: _____

Company Insured Works For: _____

2nd Insurance (If Applicable)

Primary Subscriber's Full Name: _____
Last First (Nickname)

Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's relationship to patient: (circle one)
Self/Spouse/Father/Mother/Step-father/Step-mother/Grandfather/Grandmother
Other (if other, indicate relationship): _____

Subscriber's Home Address: _____ City _____ State _____ Zip _____
(If different than patient)

Insurance Carrier Name: _____ Ins. Carrier Phone # _____
Please indicate State if applicable (i.e. Delta VA, BCBS AL, etc)

Subscriber ID # (if different than SSN): _____ Group #: _____

Company Insured Works For: _____

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**
****You may refuse to sign this Acknowledgement****

Carl P. Roy D.D.S., M.S., P.L.C.
2100 Lynnhaven Parkway Ste 200 Virginia Beach, VA 23456 757-471-2900
684B Battlefield Blvd. N Chesapeake, VA 23320 757-549-1115

RE: Patient (s): _____
Patient Name(s) - Please Print

I, _____ have received a copy of this office's Notice of Privacy Practices. I understand that Roy Orthodontics is unable to share information with any individuals not authorized on this form, with the exception to specific situations as outlined in Notice of Privacy Practices As such I give permission for Roy Orthodontics to share information as indicated with the following individuals.

- | <u>Name</u> | <u>Check all that apply</u> |
|-------------|--|
| 1) _____ | <input type="checkbox"/> Treatment, <input type="checkbox"/> Financial, <input type="checkbox"/> Appointment, <input type="checkbox"/> All |
| 2) _____ | <input type="checkbox"/> Treatment, <input type="checkbox"/> Financial, <input type="checkbox"/> Appointment, <input type="checkbox"/> All |
| 3) _____ | <input type="checkbox"/> Treatment, <input type="checkbox"/> Financial, <input type="checkbox"/> Appointment, <input type="checkbox"/> All |
| 4) _____ | <input type="checkbox"/> Treatment, <input type="checkbox"/> Financial, <input type="checkbox"/> Appointment, <input type="checkbox"/> All |

It is further understand that the above listed individuals will be required to provide a password for inquiries via telephone which will enable Roy Orthodontics to validate the person making the request. I further understand that it is my responsibility to advise the above named individuals of the password, and that information will not be shared via telephone unless this password can be validated at the time of the call. Information requested in the office may require photo identification. Please indicate password below.

Any changes to this authorization must be requested in person by completing an updated authorization.

Printed Name (Parent/Guardian if patient is under 18)

Relationship to Patient(s)

Signature

PASSWORD (please print)

Current Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgement could not be obtained because:

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

Roy Orthodontics

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 September 23, 2008 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 this Notice at any time. For more information on 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 for 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 Patients 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 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 bottom 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 \$.10 for each page, \$10.00 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.)

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 13, 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 disclosures 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 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 of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may write to us using the contact information listed at the end of this Notice. You may also 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.

2100 Lynnhaven Parkway Suite 200 Virginia Beach, VA 23456 (757) 471-2900 Fax (757) 471-3804
684 Battlefield Blvd. N. Chesapeake, VA 23320 (757) 549-1115 Fax (757) 549-6015