Name:_____

Date:_____

OFFICE AND FINANCIAL POLICIES
DR. BARTON H. FOUTZ. D.D.S.

Dr. Foutz and his staff would like to welcome you to our office. We appreciate your confidence in choosing us for your dental care needs.

If you have been referred to us by a friend, or an associate, or perhaps another dentist, please let us know on the Patient Information form. We would like you to take just a moment to read this information sheet and familiarize yourself with our office and financial policies. This will help eliminate any misunderstanding there may be regarding billing. You will be asked to sign the bottom of the Office and Financial Policy, and it will be retained in your permanent patient chart.

SCHEDULING:
We follow standard scheduling practices in this office. Should you need to cancel an appointment you have already scheduled, please let us know 24 hours in advance. We do not accept cancellation on our answering machine, but accept all other messages. *****THERE IS A $100.00 BROKEN APPOINTMENT FEE. THIS WILL BE ADDED TO YOUR CURRENT BALANCE.** We will make every effort to reach you the day before your appointment to remind you of your appointment, at which time you may tell the front office of any scheduling changes you wish to make.

INSURANCE COVERAGE:
Regardless of your insurance status, you are ultimately responsible for the balance on your account for services rendered. We work with most insurance policies in this office, however, **WE DO NOT ACCEPT INSURANCE AS A DIRECT PAYMENT ON THE FIRST FEW PROCEDURES.** Insurance can only be accepted as direct payment after your treatment plan has been pre-authorized. This can only be accomplished by having an initial complete exam. Until you have a treatment plan pre-authorized, you will be responsible for paying for your visits. Please be sure to bring all current insurance information with you on your first visit. We will gladly submit your Insurance Claim to your insurance company for you along with a statement for services rendered or pre-authorized. If you are covered by a Secondary Insurance Policy, please bring that claim form as well.

PAYMENT:
PAYMENT IS EXPECTED AS SERVICES ARE RENDERED THE DAY OF YOUR APPOINTMENT. Our office does not offer financing however, third party financing is available on approval of credit. Finance charges will apply. For your convenience, we accept cash, personal checks, Discover, American Express, Visa,

MasterCard and Care Credit. The full balance will be due. **WE WILL NOT ACCEPT PARTIAL PAYMENTS.** If a number of visits are required to complete your treatment plan, financial arrangements may be discussed with Dr. Foutz.

****ONCE YOUR ACCOUNT HAS REACHED 90 DAYS OVERDUE AND YOU HAVE NOT MADE ANY PAYMENTS TOWARD YOUR BALANCE IN THAT TIME, YOUR ACCOUNT WILL BE TURNED OVER TO A COLLECTION AGENCY AS DELINQUENT****

It is very important to Dr. Foutz and his Staff that you have a complete understanding of these policies, as well as any treatment plans you may be receiving. If, at anytime, you do not fully understand your treatment plan, please do not hesitate to ask our staff any questions.

TERMS AND CONDITIONS

1. This is to certify that I, the undersigned, consent to the performing of all dental and oral surgical procedures agreed to be necessary or advisable.
2. I understand and agree that, (Regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I also authorize and request any insurance benefits to be paid directly to Dr Barton Foutz.
3. I understand that interest at the legal prevailing rate may be added to the Past Due Balance.
4. I agree to pay for all collection or legal fees and costs reasonably incurred in connection with obtaining payment for this account.
5. I answered all the questions correctly to the best of my knowledge and understand all the statements herein.

Thank You for taking the time to read these policies.

Dr. Barton H. Foutz and Staff

I have read and understand these policies as set before me.

_____

Signature

Date:_____

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Barton H Foutz DDS to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Barton H Foutz DDS's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Barton H Foutz DDS may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Barton H Foutz DDS does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Barton H Foutz DDS already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____ Date: _____

Dental Team: Give a copy of this signed form to the patient. Save the original in the patient's file.

MEDICAL HISTORY
AND
GENERAL INFORMATION

1. (About you)

Date_____ Cell#_____ Email:_____

Name of Patient_____

Address_____

City_____ State_____ Zip_____

Telephone_____ Work_____

Birthday_____ Age_____

Married_____ Single_____Divorced_____

Occupation_____SSN_____

Employer_____

Address_____

City_____State_____ Zip_____

If Student: Name of School_____

Telephone_____Grade_____

PREFFERED CONTACT: (Check One)
HOME
CELL
TEXT
EMAIL

(Your Spouse)

Name_____

Occupation_____

Employer_____

Address_____

City_____State_____ Zip_____

Telephone_____ Ext._____

2. (Account Information)

Person Responsible For Account (Guarantor)

Name_____

SSN#_____-_____-_____

Birthdate_____Age_____

Employer_____

Address _____

City_____State_____ Zip_____

Telephone_____

Closest Relative Not Living With You: (Parents)

Name_____

Address_____

City_____State_____ Zip_____

Telephone # _____ Work_____

3. Referred To Our Office By:_____

Person To Contact For Emergency:_____

Telephone _____Work_____

4. Insurance Information: Primary Carrier:_____

Union or Local #_____ Date Employed_____

Employee Name_____Employee SS#_____

Employee Date of Birth_____

Secondary Carrier: Ins. Co._____ Union Local #_____

Employee Name_____ Employee SS#_____

Employee Date of Birth_____

LIST MEDICATIONS YOU ARE TAKING BELOW: Medical History Review Updated:

/_____
/_____
/_____
/_____
/_____
/_____
/_____
/_____
/_____

Sex: _____ If female please answer the following: Y N Are you taking Birth Control Pills?
Y N Are you pregnant? If yes, # of weeks _____ Y N Are you nursing?
Please answer the following: Y N Do you smoke or use tobacco? Height:_____ Weight:_____

Medical History: Do you have or had any of the following? (Please circle)

Allergies To Drugs	Psychiatric Care	Bad Breath
Allergies To Anesthetics	Epilepsy	Food Impaction
History Of Heart Problems	Frequent Headaches	Burning Tongue
Congenital Heart Defect	Sinus Problems	Unfavorable Dental Experience
Angina Pectoris	Thyroid Problems	Fingernail Biting
Heart Attack	Difficulty Breathing	Cheek Biting
Mitral Valve Prolapse	Emphysema	Teeth Sensitivity
Heart Murmur	Tuberculosis	Bleeding Gums, How long
Artificial Heart Valve	Ulcers	Clenching or Grinding
Rheumatic Fever	Venereal Disease	Pain in Jaw Joints
High Blood Pressure	HIV + AIDS	Frequent Blisters on Lips
Stroke	Drug Abuse	Recent Eye Surgery
Neurological Problems	Alcohol Abuse	
Radiation Therapy	Cosmetic Surgery/Implants	
Cancer – Chemotherapy	Herpes	
Excessive Bleeding	Recent Operation _____	
Anemia	Arthritis	
Asthma	Diabetes/Hypoglycemia	
Kidney Problems	Liver Problems Or Hepatitis	

Allergies: (please circle)

Y N Aspirin	Y N Codeine	Y N Dental Anesthetics
Y N Erythromycin	Y N Jewelry	Y N Latex
Y N Metals	Y N Penicillin	Y N Tetracycline

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2. I understand and agree that, (Regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I also authorize and request any insurance benefits to be paid directly to dental associates.
3. I understand that interest at the legal prevailing rate may be added to the Past Due Balance.
4. I agree to pay for all collection or legal fees and costs reasonably incurred in connection with obtaining payments for this account.
5. I answered all the questions correctly to the best of my knowledge and understand all the statements herein.

Date_____ Patients Signature (If minor, parent's signature)_____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

{BARTON H.FOUTZ DDS}

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)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

{BARTON H FOUTZ DDS}

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 1, 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 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.___ for each page, $20.00 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. 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.

Contact Officer: RaNae Howard_____

Telephone: 702-792-5929_____Fax: 702-792-2850_____

E-mail: DrFoutzDental@gmail.com_____

Address: 2510 Wigwam Pkwy Suite 100 Henderson, NV 89074_____