



Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing dental health care services to you, to pay your dental health care bills, to support the operation of the dental practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your dental health care and any related services. This includes the coordination or management of your dental health care with a third party. For example, your protected health information may be provided to a dentist or physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but

are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, 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 dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home or cellular number and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office for an accounting or insurance matter. We may also mail a postcard reminder or billing statement to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively

(i.e. electronically).

You may have the right to have your physician amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer, Michelle, of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

Randolph Dental
320 North 3rd St
7th Floor
Burlington, IA 52601
319-753-1600



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)



RANDOLPH DENTAL

COMPREHENSIVE DENTAL SERVICES

OFFICE PAYMENT POLICY

The following is an outline of our office payment policies. Please acquaint yourself with them and then sign below to acknowledge your understanding and acceptance of them.

FEES

Please feel free to discuss our fees with us at any time. Before any dental treatment begins, the patient and/or responsible party will receive a consultation regarding treatment plan and cost. We attempt to keep our fees at a fair level that reflects the quality of care provided in our office. Prompt payment will enable us to keep our fees lower for everyone; therefore, **payment is due at the time services are rendered**. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required.

We accept cash, check (returned check fee \$20), Visa, MasterCard, and Discover. We also offer financing options with no interest up to 12 months where applicable, or longer payment terms with competitive interest rates through Care Credit.

INSURANCE

As a courtesy to our patients with insurance, we will file your insurance claim and allow you to pay only your deductible and/or estimated co-payment as services are rendered. This amount is also due at the time of the appointment. Please remember that the contract is between you and your insurance company, and **your total balance in our office is always your responsibility**. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your insurance policy or payment from your insurance. If for any reason there is a balance remaining after your insurance company's payment, you will be billed for that amount with a statement. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier. We will assist in obtaining payment from the insurance company in any way we can.

PAST DUE ACCOUNTS

Account aging begins the day your charges are incurred. Unless arrangements are made in advance, accounts that are 60 days past due will begin to incur an interest charge of 1.5% per month (18% per annum) on the outstanding balance until the account is paid in full. Accounts that are ninety (90) days past due without any effort to make payment will be turned over to a third party collection agency. This action may cause an additional maintenance fee to be added to your account. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care. You will also lose any implied or expressed warranties related to completed or in progress work.

I have read, understand and agree to adhere to the financial policies outlined above.

Full Name _____

Date _____

Health History Form



American Dental Association
www.ada.org

E-mail:

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: <i>Include area code</i>		Business/Cell Phone: <i>Include area code</i>	
<div>LastFirstMiddle</div>			()		()	
Address:			City:		State: Zip:	
<div>Mailing address</div>						
Occupation:			Height: Weight:		Date of birth: Sex: M F	
SS# or Patient ID:			Emergency Contact:		Relationship: Home Phone: Cell Phone:	
					() () <i>Include area codes</i>	
If you are completing this form for another person, what is your relationship to that person?						
Your Name			Relationship			
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)						
Active Tuberculosis..... Yes No DK						
Persistent cough greater than a 3 week duration..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
Cough that produces blood..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
Been exposed to anyone with tuberculosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.						

Dental Information For the following questions, please mark (X) your responses to the following questions.

<div>Yes No DK</div> <div>Do your gums bleed when you brush or floss? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Are your teeth sensitive to cold, hot, sweets or pressure? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Does food or floss catch between your teeth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Have you had any periodontal (gum) treatments? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Have you ever had orthodontic (braces) treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Is your home water supply fluoridated? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Do you drink bottled or filtered water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY</div> <div>Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>What is the reason for your dental visit today?</div> <div>How do you feel about your smile?</div>	<div>Yes No DK</div> <div>Do you have earaches or neck pains? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Do you have any clicking, popping or discomfort in the jaw? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Do you brux or grind your teeth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Do you have sores or ulcers in your mouth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Do you wear dentures or partials? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Date of your last dental exam: What was done at that time?</div> <div>Date of last dental x-rays:</div>
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Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<div>Yes No DK</div> <div>Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Physician Name: Phone: <i>Include area code</i></div> <div>()</div> <div>Address/City/State/Zip:</div> <div>Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>If yes, what condition is being treated?</div> <div>Date of last physical exam:</div>	<div>Yes No DK</div> <div>Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>If yes, what was the illness or problem?</div> <div>Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:</div> <div></div> <div></div> <div></div> <div></div>
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Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes No DK	Yes No DK		
Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date: _____ If yes, have you had any complications? _____				Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED		
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____		
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment began: _____				WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes No DK	Yes No DK		
Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
				Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.						
Yes No DK			Yes No DK			Yes No DK
Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Hepatitis, jaundice or
Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)			Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			If yes, specify: _____
Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>			Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Specify: _____
Yes No DK			Yes No DK			Yes No DK
Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Type of infection: _____
Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Persistent swollen glands
Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			If yes, date: _____			Severe headaches/ migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other congenital heart			AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
Name of physician or dentist making recommendation:					Phone:	
Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Please explain:						

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

Date:

FOR COMPLETION BY DENTIST

Comments: _____

