ORAL & FACIAL SURGERY CENTER of VIRGINIA

FINANCIAL POLICY

1. Payment for services rendered is due the day of the appointment.
2. A payment of $50 was collected to schedule today's appointment. That $50 will be applied towards the consultation cost.
3. Our office will assist with filing insurance; however, the Patient or Parent/Guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company. When treatment co-pays and fees are quoted by the office, these are estimates only; your actual insurance coverage may be less or more. The insurance company is unable to provide the exact amount that will be paid until the claim is processed.
4. Personal checks that are returned due to insufficient funds are subject to a $35.00 NSF fee.
5. Appointment cancellations with less than 48 hours' notice are subject to a fee of $60.00 and appointments scheduled for two (2) hours or longer are subject to a $200.00 fee.
6. All accounts over 60 days are considered past due. Such accounts are subject to 1.5% monthly finance charges. Past due accounts may be sent to an authorized collection agency. Accounts sent to a collection agency will be assessed a 30% collection charge on the unpaid balance. The Parent/Guardian will also be liable for any applicable attorney fees and court costs. Accounts that have been referred to an outside collection agency will be placed on a CASH ONLY basis for any future treatment.
7. We are required by the State of Virginia to keep patient records for three years past the final date of treatment. If you are moving or leaving the practice for any reason you may request a copy for your records. There may be a minimal charge for the release of your records.
8. I understand that the fee estimate listed for this dental care is only good for a period of six (6) months from the date of the patient examination.
9. All emergency dental services must be paid for at the time services are performed.
10. I authorize payment of dental insurance benefits payable to Oral Facial Surgery Center of VA, unless payable to me directly per the Insurance Plan.
11. I authorize release of any information relating to any insurance claims to the relevant insurance company.

I, as the Responsible Party, acknowledge that I have read all of the above information, and that I understand it completely.

Patients Name Printed Date

Parent/Guardian Signature Date

3787 Fettler Park drive, Suite A8, Dumfries, VA 22025

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HEALTH HISTORY FORM

Patient's Name	Date of Birth	SSN#
Street Address	City/State	Zipcode
Home #	Cell #	Work#
Email add		
Insurance	GroupID#	Member ID#

Please complete the Health History so that we may provide the best possible care; the doctor will discuss the History with you prior to beginning treatment.

I. GENERAL INFORMATION

Height_____ Weight_____

- Are you in good health? YES NO (circle)
- Are you now under a physician's care for a particular problem? If so, describe:_____

_____

- Physician name and telephone #

_____

- Date of last physical exam

_____

- Has there been any change to your general health in the past year? If so, describe:

_____

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• Have you ever had any serious illness? If so, describe:

_____

• Have you been hospitalized or had surgery? If so, describe:

_____

II. DO YOU HAVE OR HAVE YOU EVER HAD: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Cardiovascular disease? (heart attack, coronary artery disease, angina, chest pain, irregular heart rate or palpitations, congenital heart disease, rheumatic heart disease, murmur)
2. High Blood pressure?
3. Stroke?
4. Heart Surgery? (bypass or stent)
5. Pacemaker?
6. Respiratory disease? (asthma, emphysema, COPD, chronic cough, bronchitis)
7. Epilepsy or seizures?
8. Fainting or dizziness?
9. Bleeding disorder, anemia?
10. Blood transfusion?
11. Bruise or bleed easily?
12. Liver disease? (jaundice, hepatitis)
13. Kidney disease?
14. Diabetes? (Type?)
15. Thyroid disease?
16. Arthritis?
17. Stomach ulcers or acid reflux? (GERD)
18. Other GI disease?
19. Glaucoma?
20. Osteoporosis?
21. Implants or join replacements?
22. Radiation therapy?
23. Chemotherapy?
24. Sinus or nasal problems?
25. Seasonal allergies?
26. Snoring or sleep apnea?
27. Psychiatric illness?
28. Disease or medication that has depressed your Immune system?
29. Organ transplant?
30. Drugs / substance Abuse?

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III. ARE YOU TAKING ANY OF THE FOLLOWING: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Antibiotics?
2. Anticoagulants or blood thinners? (Coumadin, Plavix, Eliquis, Pradaxa)
3. Aspirin or ibuprofen?
4. Steroids? (cortisone, prednisone, etc.)
5. Tranquilizers, sleep aids, antidepressants, narcotics?
6. Insulin or oral anti-diabetic drugs?
7. Please list **ALL** medications you are taking, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

Have you ever taken?

8. Diet pills?
9. Bisphosphonate bone density medications?

   Reclast, Foasmax, Actonel, Boniva, Aredia, Zometa)
10. Have you ever been advised to **not** take a medication?

_____ _____

_____ _____

_____ _____

_____ _____

IV: ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Local anesthesia? (novocain, etc.)
2. Penicillin or other antibiotics?
3. Sedatives, barbiturates?
4. Aspirin or ibuprofen?
5. Codeine or other pain killers?
6. Latex or rubber products?
7. Chemicals or jewelry? (rash or sensitivity)
8. Food products? Soy? Eggs?
9. Other allergies or reactions?

   If so, please list:

   _____

   _____

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V. ADDITIONAL INFORMATION: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Do you smoke or chew tobacco?

   How much?_____ For how long?_____
2. Is there any past history of alcohol or chemical dependency?
3. Do you grind or clench your teeth?
4. Have you or an immediate family member had any problem associated with anesthesia?
5. Is there any emotional or psychiatric illness that may affect the care we provide?
6. Have you had any serious problems associated with previous dental treatment?
7. Do you have pain, clicking or popping of the jaw joint, or difficulty opening mouth?
8. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?
9. Do you wish to talk to the doctor privately about anything?

VI: FOR FEMALE PATIENTS ONLY

1. Are you pregnant, or is there any chance you might be pregnant?
2. Are you nursing?

If you are using Oral Contraceptives, it is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives.

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care. I have read and understand the above information.

_____

Patient/Guardian signature Date:

_____

Doctor's signature Date:

3787 fettler Park drive, Dumfries, VA22025

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HIPAA NOTICE OF PRIVACY ACT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY

How we may use and disclose your health information:

1. ***Treatment:*** We may use and disclose Health Information for your treatment and to provide you with treatment related health care services.
2. ***Payment:*** We may use and disclose Health Information so that we or others may bill and receive payment from you, insurance company, or a third party for the treatments and services you received.
3. ***Health Care Operations:*** We may use and disclose Health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.
4. ***Appointment reminders, treatment alternatives, and health related benefits and services:*** We may use and disclose Health Information to remind you of your appointment
5. ***Individuals Involved in Your Care or Payment of Your Care:*** We may share Health Information with a person involved in your medical care or payment for your care. Such as family or your close friends or guardian.
6. ***Research:*** Under certain circumstance, we may use and disclose your Health Information for research purposes.

Special Situations

As Required by Law: we may disclose Health Information as required by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the safety and health of public or another person.

Business Associates: We may use and disclose Health Information to our business associates who function on our behalf or provide us with services such as billing.

Organ And Tissue Donation: If you are an organ donor, we may use or release Health Information to organization that handles organ procurement, banking or transportation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities.

Workers' Compensation: We may release health information for workers' compensation or similar programs.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report birth and deaths; report child abuse or neglect; report reactions to medication or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or condition; and report to appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose Health Information to health oversight agency for activities authorized by law.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose Health Information in response to administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal
conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorize federal officials so they may provide protection to the president, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care. 2) To protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

Your Rights
You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have the right to inspect and copy Health Information that may be used to make decision about your care or payment of your care. This includes medical and billing records. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend: If you feel that Health Information we have is incorrect, or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures w made of Health Information for purposes other than treatment, payment, and health care operations for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions: You have the right to request a restriction of limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in you care or the payment for your care, such as a family member or friend. To request a restriction, you must make your request, in writing, to our office. We are not required to agree to your request. If we agree, we will comply with you request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about the medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable request.

Patient Name : _____ Date: _____

Patient signature: _____