Welcome to

Dr. Ken Chancey's Dental Practice

Member, American Dental Association

Thank you for choosing us to help you with your dental care

DEPENDENT CHILDREN PATIENT INFORMATION FORM

Date _____

If your child is covered by insurance, please give any insurance cards (primary and secondary, if applicable) to the front desk receptionist so that we may make copies.

Personal Information:

Dependent child's full name _____

Address _____

What does your child like to be called? _____

Phone _____

Child's Birthdate _____ SS# _____

Child's School _____ Grade _____

Child's Hobbies/Interests? _____

Child's Medical/Dental History:

Name and City of Child's Physician _____

Please list any medications your child is taking:

_____

Any allergies or allergic to any medication? _____

Please list any other past or present conditions concerning your child's health:

_____

When was your child's last visit to the dentist? _____

Is your child anxious about going to the dentist? _____

Has your child ever used the "Gas" in the dental office before? _____

Has your child ever used liquid or pill sedation in the dental office before? _____

OVER > > >

Has your child's experience been good at previous dental offices? _____

If not, what happened to make the experience unpleasant?

_____

_____

Business Information

Parent/Guardian Names_____

Billing address(es) _____

Home Phone_____ Cell_____ Work_____

_____

Name of Primary Insurance Company _____

Primary Policy Holder's Name _____SS#_____

Birthdate _____

Name of Secondary Insurance Company _____

Secondary Policy Holder's Name _____SS#_____

Birthdate _____

Who is responsible for paying this account? _____

How did you hear about us? _____

Name of referring person is _____

Please indicate the method of payment as service is rendered ☐ Cash ☐ Credit Card ☐ Check

If you are interested, ask us about CARE CREDIT, an easy financing plan endorsed by the American and Alabama Dental Association

The two statements below must be signed.

I fully understand that I am ultimately responsible for the payment of this account. When insurance is involved, I am aware that I am responsible for the portion of this bill that the insurance company will not pay.

Signed _____

In consideration of the services to be rendered by the Dentist and staff to the patient, the undersigned shall be personally obligated to pay for the services in accordance with the Dentist's standard rates and terms of payment, whether or not the undersigned is the patient or the patient's agent or representative and whether of not the services are covered by health insurance or any other source or reimbursement. Accounts more than sixty (60) days past due will bear interest at the rate of one and one-half percent (1½%) per month. The undersigned also agrees to pay collection expenses and reasonable attorney fees if this account is referred for collection.

Signed _____

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 14 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 **$1.00** for each page, $ **15.00** 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 **Dr. Kenneth Chancey**

Telephone: **(334)347-0036** Fax: **(334) 308-2217**

E-mail:

Address: **P. O. Box 311087, Enterprise, AL 36331**

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

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 frdm obtaining acknowledgement
- ☐ Other (Please Specify)

Kenneth W. Chancey, DMD, LLC

Family and Cosmetic Dentistry
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Enterprise, AL 36330
Office phone: (334)-347-0036
Office E-mail: office@doctorchancey.com
Website: www.doctorchancey.com

Informed Consent
To File Your Insurance Forms For You

Thank you for allowing us to serve you with our excellent dental care.

We deal with many insurance companies and 100's of insurance plans. Insurance companies can be difficult to deal with. Examples: when we get your benefits from your insurance company representatives, the insurance company representatives will not guarantee the information that they give us about your benefits to be accurate. They give us their "Disclaimer"; they claim that they have the final say-so depending on what they call a" Medical Necessity".

We will endeavor to keep you informed and give you the most accurate estimate of your benefits and your out-of –pocket financial obligations.

Since insurance companies have the final say in your benefits, we cannot guarantee the accuracy of our estimates concerning your financial obligations

As with all insurance companies, the insurance companies are responsible to the patients and the patients are ultimately responsible for total payments of their accounts.

Thank you for understanding.
Sincerely,
Dr. Kenneth W. Chancey and Staff

I have read and understand the above. I give Dr. Chancey and his Staff permission to file my insurance claims for me. I understand that insurance companies are responsible to honor their contracts with the patients, and are answerable to their customer-patients. I understand that ultimately, the financial responsibility for full payments for my dental services is mine.

_____	_____	_____
Patient's Signature	**Please print your name**	**Date**