Julie Thomas, D.D.S. Welcome to our Practice

Patient Information:

Patient Name:_____ Preferred Name: _____ Today's Date:_____

O Mr. O Mrs. O Other _____SSN:_____-_____-_____ Marital Status: O Married O Single O Other_____

Date of Birth:_____ Cell Phone:_____ Home Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer : _____ Work Phone: _____

Preferred Contact Methods: O Cell Phone O Text Message O Email O Home Phone O Other: _____

Drivers License Number: _____ Emergency Contact: _____

Phone: _____ Relationship: _____

Spouse Information (If applicable)

Name:_____ Date of Birth: _____ SSN:_____-_____-_____

Address (If different):_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Work Phone: _____ Drivers License Number:_____

Primary Dental Insurance Information (If applicable)

Insured Name:_____ Relationship to Patient: _____

Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Address: _____City:_____State: ____ Zip: _____

Employer: _____ ID Number (if no ID Number SSN): _____

Group Number (Plan Number, Local or Policy Number):_____ Effective Date: _____

Secondary Dental Insurance Information (If applicable)

Insured Name:_____ Relationship to Patient: _____

Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Address: _____City:_____State: ____ Zip: _____

Employer: _____ ID Number (if no ID Number SSN): _____

Group Number (Plan Number, Local or Policy Number):_____ Effective Date: _____

Medical History

Name:_____ **Date:** _____ **Date of Birth:** _____

Physicians Name: _____ **Physicians Phone Number:** _____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

What medications are you taking? _____

Are you allergic to any medications? If yes which one(s): _____

Do you take a Pre-med? If yes which one? _____ **For What:** _____

Do you have any of the following diseases/Problems?

- O AFIB
- O Anemia
- O Artificial Joint(s) _____
- O Arthritis
- O Asthma/Respiratory Problems
- O Autoimmune Disorder
- O Blood Disorder
- O Cancer (if yes type) _____
- O Chronic Pain
- O COPD
- O Congestive Heart Failure
- O Diabetes
- O Dizziness/Fainting
- O Dementia
- O Depression/Anxiety
- O Epilepsy/Seizures
- O Excessive Bleeding
- O Fibromyalgia
- O Gerd
- O Head Injury
- O Heart Disease
- O Hepatitis
- O Herpes/Cold Sores
- O High Blood Pressure
- O HIV/AIDS
- O Kidney Disease
- O Liver Disease
- O Low Blood Pressure
- O Mental Health Disorder
- O Multiple Sclerosis
- O Narcolepsy
- O Osteoporosis
- O Pacemaker
- O Radiation/Chemo
- O PTSD/Trauma Disorder
- O Rheumatism
- O Sinus Problems
- O Stroke
- O Tachycardia
- O Traumatic Brain Injury (TBI)
- O Tuberculosis
- O Tumors
- O Are you taking blood thinners? (If yes please circle) Coumadin, Jantovin, Xarelto, Pradaxa, Eliquis, Heparin, Lovenox
- O Other: _____
- O Have you ever taken any bisphosphonate medications such as (please circle if yes) Boniva, Fosamax, Actonel, Prolia, Zometa, Aredia, Reclast Other:_____

If there is any other information or physical condition which you feel would be of value to us in your dental treatment, please let us know:

_____

_____

My signature below attests that my medical history is accurate and complete to the best of my knowledge. There are no other medications/medical conditions that have not been listed.

Signature:_____ Date:_____

Update:_____ Date:_____

Julie M. Thomas, D.D.S.

drjuliethomasdds.com
1437 South Main Street • North Canton, OH 44720

frontdesk@drjuliethomas.co
(330)244-9081

Consent for services and Financial Policy

Welcome to Julie M. Thomas, DDS. We are happy to have you as our partner and look forward to offering you and your family the finest dental care available. We Know that providing complete comprehensive dental services includes discussing all treatment and financial information. This practice depends upon reimbursement from the patient and the insurance company for costs incurred in their visit at the time of service. Therefore, the patient is responsible for their financial obligation.

All emergency dental services must be paid for in cash at the time services are performed.

Before treatment is performed, we will discuss treatment and your financial responsibility. This will allow you to fully understand your dental treatment and what to anticipate in fees.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, Mastercard, Discover, American Express and Care Credit.

Patients with dental insurance understand that all insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. We will be more than willing to help you navigate your dental insurance. Insurance is not a guarantee of payment: it often does not cover all the costs involved in treatment. You as the patient must understand that the fee estimate listed is just that, an ESTIMATE. If the insurance company does not pay you are responsible for the difference. As a courtesy, we will be happy to file your claim for you and make sure you have active dental benefits - if you present your dental insurance card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your dental insurance prior to treatment.

Treatment plans and financial estimates developed in this practice are subject to change depending on the specific dental condition.

Any deductible or estimated co-payment amount will be due at the time of treatment. In consideration for the services rendered by the doctor, you as the patient agree to pay in full the estimated portion at the time of service and agree to pay all the remaining balance once insurance has been paid. A service fee of 5% per month on the unpaid balance will be charged on all accounts exceeding 60 days.

The patient grants permission to Dr. Julie and staff to telephone them at any time to discuss matters related to this form.

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening arises. If an appointment is not canceled at least 24 hours in advance, or if you fail to keep your appointment, you will be charged a fifty-five-dollar ($55) fee. This fee will not be covered by your insurance company.

I have read and fully understand the above conditions of treatment/financial policy and agree to its content.

Signature _____ **Date** _____

Response Date: _____

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BROKEN APPOINTMENT POLICY

When you reserve a time with us please make every attempt to make your appointment. We do not "double book" as many offices do. This time is set aside specifically for you. Two weeks prior to your appointment you will receive an email, text message or a phone call if you do not wish to receive text messages. When you receive this message, please call, text or email us to confirm the time that you have already reserved with us.

We have a 1-BUSINESS DAY cancellation policy. If you need to change or reschedule your reserved time with us, please give us at least a 1-

BUSINESS DAY notice so that we will be able to fill this time with others waiting for treatment. There will be a Broken Appointment Fee of $55.
This may sound harsh, but please understand that if you have TWO broken appointments, we reserve the right to release you as a patient and ask that you seek treatment at another Dental Practice. Thank you for understanding this policy.

LATE ARRIVAL

If you are over 15 minutes late for your appointment, we reserve the right to reschedule your appointment for a later time. Please understand that we strive to stay on time for your appointment as well as those patients that follow you. By signing below, you have read, and understand this agreement.

*

◯ Yes ◯ No

Patient or Parent

_____

_____

ARE YOU FAMILIAR WITH OUR NO SHOW POLICY?

*◯ Yes ◯ No

1st No Show- Reminder letter mailed

2nd No Show- Letter sent explaining risk of being dismissed from the practice

3rd No Show- Dismissal letter sent of removal from the practice

Our office makes every attempt to do reminder phone calls and text messages for appointments. However, this is done as a courtesy when our time allows. If you do not receive a reminder phone call, it is still your responsibility to know when your appointment is and come as scheduled or call to cancel if you cannot make the appointment. Please call at least 48 hours prior to cancel your appointment to avoid dismissal from the practice!

Thank you for your cooperation and understanding.

_____

Response Date: _____

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Julie M. Thomas

1437 South Main St., North Canton, Ohio 44720

NOTICE OF PRIVACY PRACTICES

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

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical 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, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to another dentist or doctor.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

Most uses and disclosure of psychotherapy notes;

Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

Disclosures that constitute a sale of PHI under HIPAA; and

Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.

The right to inspect and copy your PHI.

The right to amend your PHI.

The right to receive an accounting of disclosures of your PHI.

The right to obtain a paper copy of this notice from us upon request.

The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of December 10, 2003 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Signature _____ **Date** _____

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

Attn: Practice Compliance Officer

Dr Julie Thomas

Response Date: _____