

NAME: _____ DATE OF BIRTH: _____
 ADDRESS: _____ CITY/STATE: _____ ZIP _____
 TELEPHONE: _____ CELL PHONE: _____
 SOCIAL SECURITY: _____ SEX: _____ SPOUSE: _____
 PLACE OF EMPLOYMENT: _____ TELEPHONE: _____
 OCCUPATION: _____ RECOMMENDED BY: _____
 IS ANY OTHER FAMILY MEMBER A PATIENT HERE? YES/NO NAME: _____
 E MAIL ADDRESS: _____
 REASON FOR TODAY'S VISIT: _____ DATE OF LAST DENTAL VISIT: _____
 DO YOU LIKE THE APPEARANCE OF YOUR TEETH.....YES/NO
 WHAT WOULD YOU CHANGE? _____

NAME OF PHYSICIAN: _____ TELEPHONE: _____
 ARE YOU UNDER PHYSICIAN'S CARE NOW.....YES/NO
 NATURE OF TREATMENT: _____

BLOOD THINNER YES / NO

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UPPER...YES / NO How many years? _____
LOWER...YES /NO How many years? _____

DRIVERS LICENSE # _____

Date _____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED

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 REVIEW IT CAREFULLY.

Effective Date: _____

OUR LEGAL DUTY

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice currently in effect

Protected health information includes information that identifies you and relates to your dental or health condition, treatment, or payment for services.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment

We may use or disclose your health information to provide, coordinate, or manage your dental care.

Example: Sharing information with specialists, labs, or other healthcare providers involved in your care.

2. Payment

We may use or disclose your health information to obtain payment for services provided.

Example: Submitting claims to your dental or medical insurance plan.

3. Health Care Operations

We may use or disclose your health information for practice operations, including quality assessment, staff training, licensing, and administrative activities.

SUBSTANCE USE DISORDER (SUD) RECORDS — SPECIAL PRIVACY PROTECTIONS

Some health information related to substance use disorder (SUD) diagnosis, treatment, or referral may be protected by federal law (42 CFR Part 2) and receives additional confidentiality protections.

Important information about SUD records:

- We may not use or disclose SUD records for treatment, payment, or healthcare operations without your written consent, except as permitted by law.
- These records will not be used or disclosed in any civil, criminal, administrative, or legislative proceeding against you without your written consent or a court order.
- If state or federal laws are more restrictive than HIPAA, those stricter laws will apply

REDISCLOSURE NOTICE If your health information is disclosed as permitted by law, the recipient may redisclose the information, and it may no longer be protected by HIPAA.

FUNDRAISING COMMUNICATIONS (If Applicable) We will not use information protected under 42 CFR Part 2 for fundraising without giving you the opportunity to **opt out** of such communications.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- **Inspect and obtain a copy** of your health records
 - **Request corrections** to your health information
 - **Request restrictions** on certain uses or disclosures
 - **Request confidential communications**
 - **Receive a paper copy** of this Notice at any time
 - **Be notified** if your unsecured health information is breached
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OTHER USES AND DISCLOSURES

Any uses or disclosures of your health information not described in this Notice will be made **only with your written authorization**. You may revoke an authorization at any time in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and make the new Notice apply to all health information we maintain. The revised Notice will be available in our office and on our website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with:

Practice Manager:

Name: _____

Phone: _____

Or with the U.S. Department of Health and Human Services:

Office for Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

1-800-368-1019 | www.hhs.gov/ocr We will not retaliate against you for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of this Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____

We will not retaliate against you for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of this Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____

Crystal River Family Dentistry

6824 Gulf to Lake Hwy. Crystal River, FL 34429
(352) 794-6139 Fax (352) 794-6140



Offering High Quality Dental Care at Affordable Prices

Insurance Policy

We at Value Dental Care try very hard to keep expenses down so that we can pass these savings on to our patients. This requires us to have payment on services rendered basis, not a monthly billing system. BUT

OUR PATIENTS WITH INSURANCE MAY USE THIS INSURANCE AS PAYMENT.

Before treatment is scheduled, our office receptionist will be contacting your insurance company to ascertain your yearly deductible amount and eligibility. Our receptionist will also inquire as to how much your insurance company will cover. This can usually be done while you wait and will be helpful information when the doctor and assistant review with you your estimated cost of treatment. The insurance company will quote benefits over the phone but will not guarantee payment. Please remember that we are all at their mercy when benefits are quoted.

We will also be willing to schedule treatment over a longer period of time, only if the doctor agrees, so that you may fit these expenses into your budget.

If you do not understand this policy or need to make financial arrangements, please feel free to talk with our office supervisor before treatment.

YOUR INSURANCE I.D. CARD, CLAIM FORM, AND INSURANCE BOOKLET ARE IMPORTANT PARTS OF OUR ABILITY TO SERVE YOU FASTER. THEREFORE, PLEASE HAVE THESE FORMS ON YOUR FIRST VISIT. If you do not, please let the receptionist know right away.

If you are a dependent, the employee's signature, social security number, and date of birth are a necessary parts of our insurance claim.

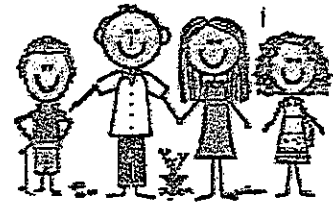
PLEASE DO NOT MISUNDERSTAND AN ASSIGNMENT DOES NOT RELIEVE YOU OF THE RESPONSIBILITY OF THE BALANCE DUE ON YOUR ACCOUNT. FUTURE ASSIGNMENTS ARE BASED ON PAST CREDIT RECORD.

I certify that I have read and understand the above.

Patient signature: _____ Date: _____

Value Dental Care

Dr. Ivelyn Santini, DMD & Associates
6824 Gulf to Lake Hwy. Crystal River, FL 34429
(352)794-6139 Fax (352) 794-6140



Offering High Quality Dental Care at Affordable Prices!

Insurance Guarantee of Payment

Name: _____ Phone Number: _____

It is the policy of this office to file your insurance AS A COURTESY.

If payment has not been made by your insurance carrier after your claim has been filed for six (6) weeks, you will be billed accordingly for these charges. It is then your responsibility to follow up with your insurance company as to the reason no payment has been made. Insurance companies do not guarantee payment on either written or verbal verification. Insurance coverage is a contract between the patient's employer and the insurance company. The dentist does not enter into this contract, thus cannot be responsible for the lack of payment on any assignment. We will be more than happy to assist you whenever possible.

I hereby agree to guarantee and promise to pay Value Dental Care all charges incurred in the treatment of the above named patient, including those expenses by any insurance policy presently in force. All deductibles amounts and non-covered expenses are to be paid in advance. ALL DISALLOWED PROCEDURES WILL BE PAID IN FULL WITHIN TEN (10) DAYS OF NOTIFICATION. If your insurance is terminating, the completion date will be submitted to your insurance company. VISA, Master Card, Discover, and American Express are available to use for these unpaid balances. This office will notify you prior to the charge. (If collection actions are necessary, we will not accept any future insurance assignments from your family.)

I hereby authorize the release of information to my insurance company. I authorize all monies due to me through my insurance company to be sent directly to the dentist. I authorize if necessary, the dentist to request a review and/or pursue an appeal with my insurance company's claim determination. This authorization is enforced upon delivery of my written revocation.

I understand that my insurance company does not pay for cosmetic procedures or procedures covered by alternate treatment benefits, i.e. partials vs. bridges, amalgam vs. composite (white) fillings, etc. I also understand that if I elect a bridge rather than a partial denture, that I am responsible for the difference in cost since this is a cosmetic choice.

I will be responsible for the difference in price over and above the insurance payment. I have agreed with my dentist that the optimal treatment is preferred.

If any action or law in equity is brought to enforce this agreement, Value Dental Care shall be entitled to be reimbursed for reasonable attorney fees, court costs, and any other costs of collection incurred.

Signed: _____ Date: _____