Orthodontics
Bailey-Bruster & Ellis Orthodontics

Greetings!

We look forward to welcoming you to our office at your consultation appointment. Please allot approximately one hour for your appointment. This time could be shorter if you decide to print and fill out the forms ahead of time (i.e. medical history form, responsible party agreement and HIPPA form).

At your appointment, you will meet Dr. Bruster or Dr. Carter. The doctor will look at your teeth and advise you how orthodontic treatment will benefit you. Also, we will answer any questions you may have at that time. If you find it necessary to change this appointment, please call the office and we will do all we can to arrange another mutually satisfactory time.

Our goal is to serve you with excellence in a fun and supportive environment so that you are on your way to getting the smile that you have always wanted. We look forward to meeting you soon! ☺

Professionally yours,

BE Orthodontics
Treatment Coordinator

Highlands Grove Office Condominiums 3614 Highlands Parkway • Smyrna, GA 30082 • (770) 432-6070 • (770) 432-5122 Fax
2655 Dallas Highway • Suite 640 • Marietta, GA 30064 • (770) 420-7071 • (770) 420-7553 Fax

BE Orthodontics

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.

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.

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 authorize 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 $0.75 for each page, $5.00 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.

QUESTIONS AND COMPLAINTS

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: Jennifer Willis Telephone: (770) 432-6070 Fax: (770) 432-5122

Address: 3614 Highlands Parkway

Smyrna, Ga. 30082

BE Orthodontics

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)

_____

_____

_____

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

BE Orthodontics

Bailey-Bruster & Ellis Orthodontics

Medical and Dental History

Patient's Name_____

Physician's Name_____ Phone Number_____

Please answer the following questions:

1. Is the patient under the care of a physician? ☐Yes ☐No
   If yes, why?_____
2. Is the patient taking any medications? ☐Yes ☐No
   If yes, what?_____
3. Has patient been hospitalized in the past 2 years? ☐Yes ☐No
4. **(WOMEN)** To your knowledge are you pregnant? ☐Yes ☐No
5. Check the conditions that the patient has ever had a problem with:

☐Rheumatic fever
☐Heart murmur
☐Heart condition
☐Pacemaker
☐Stroke
☐High or low Blood Pressure
☐Bleeding disorder
☐Anemia
☐Hepatitis
☐Jaundice
☐Liver disorder
☐A.I.D.S.
☐HIV
☐Herpes
☐Venereal Disease
☐Diabetes
☐TB or Lung Disease
☐Epilepsy
☐Asthma
☐Stomach Ulcers
☐Cancer/Radiation Therapy
☐Kidney disorder
☐Back Problems
☐Arthritis
☐Glaucoma
☐Speech or Hearing
☐Joint Replacements
☐Hemophilia
☐Other _____

☐**The patient has had no history of ANY of the medical problems listed above.**

6. The patient has had an allergic reaction to:
   ☐Penicillin ☐Erythromycin ☐Tetracycline ☐Novocaine ☐Codeine
   ☐Aspirin ☐Metals ☐Latex Gloves ☐Other_____

☐**The patient has never had an allergic reaction to any drugs, medications or materials.**

I UNDERSTAND THE IMPORTANCE OF NOTIFYING MY ORTHODONTIST(S) OF ANY MEDICAL CHANGES UPON EACH VISIT.

Signature_____Date_____

Orthodontist_____Date_____

BE Orthodontics

Bailey-Bruster & Ellis Orthodontics

Patient's Name_____ Birthdate_____
School attend (if child):_____

General Dentist_____ Last Cleaning_____

Account Information/Person Responsible for Bill

Mr./Mrs./Ms._____Birthdate:_____
Last First MI

Address: _____ Home Phone:_____
Street Cell Phone:_____
Service Provider:_____
_____ SS#_____
City Zip

Email:_____

Employer_____ Work Phone:_____
How long been employed there?_____ Position_____

Name of Spouse or second parent or guardian

Mr./Mrs./Ms._____Birthdate:_____
Last First MI

Address: _____ Home Phone:_____
Street Cell Phone:_____
_____ SS#_____
City Zip

Email:_____

Employer_____ Work Phone:_____
How long been employed there? _____ Position_____

Additional family members or dependents who may become our patients:

Name	Relationship	Birthdate
_____	_____	_____
_____	_____	_____

Emergency Contact (friend or relative not living with you)

Name_____ Home Phone_____
Relationship_____ Work Phone_____

We appreciate the confidence our patients have in us and would like to know whom we may thank for referring you to our office.

Your dentist _____ A friend _____
A patient _____ Other _____

Financial Information

If you have dental insurance, please provide the following information:

Insurance Co. Name:_____ Phone Number:_____

Insurance Co. Claim Mailing Address: _____

Policy Holder Name:_____ Policy Holder SS #: _____

Member ID#:_____ Group #: _____

Dental Insurance Release

Please Note:
To better serve the needs of our patients when expediting insurance claim forms, we request your signature after reading the authorization below.

Authorization to pay Benefits to Orthodontist(s)
I hereby authorize payments directly to the orthodontist(s) of the insurance benefit otherwise payable to me for their services.
Signature on File _____

Information release
I hereby have reviewed the treatment plan and authorize the release of any information relating to my treatment or pre-authorization including x-rays and study models.
Signature on File _____

BE Orthodontics, Inc., Office Guidelines

Thank you for taking the time to fill out these patient information forms. The following guidelines are intended to help meet the needs of all of our patients.

When you make an appointment, that time and procedure is carefully planned to meet your individual needs. Please do not reschedule your appointment unless it is absolutely necessary, for it is often difficult to schedule someone else in a time that was reserved for you. If you are not able to keep an appointment, please give us as much notice as possible. If less than 48 hours is given, we reserve the right to charge you for that missed appointment time.

We are always happy to answer any questions you may have. You should be kept informed as to what treatment is needed and what it will cost. (**All fees are due at the time treatment is performed unless other arrangements have been approved in advance.)**

In the event that you or your child starts orthodontic care:
For your convenience, we will gladly file your primary (only) dental insurance claim. We will allow you to assign payment to our office so that you will not have to wait for the payments, provided we receive the following from you:

1) Copy of your insurance card and driver's license (will need with or without insurance).
2) Signatures on the insurance forms that assign benefits to our office (a signature will be required annually).

It is our office policy to bill your insurance carrier as a courtesy to you, although YOU are responsible for the entire balance. Once the carrier is billed, we will set aside that portion of the balance estimated to be paid by your insurance carrier however; if insurance, for any reason, does not pay estimated portion you will be responsible for balance.
The undersigned has read and understands the above and hereby authorizes the orthodontist(s) to perform any procedure that is deemed necessary in the best interest of the patient's health.

Signature _____Date_____

Witness_____Date_____