Welcome.

We’re glad you’re here.

We know that going to the dentist may not be at the top of your “to do” list. But, whether it’s been six months or six years since your last visit, we’re just glad you’re here.

We promise to listen to your hopes and fears, jitters and concerns. To provide care without pressure, and advice without obligation. To deliver equal doses of care and honesty, because we’re confident you’ll trust us with your health when you know we have your best interests at heart.

And we’ll stop at nothing to deliver an experience that is above and beyond what you thought dental care could be.

Patient Information

First: _____Middle: _____Last: _____Jr/Sr: _____

Street: _____City: _____State: _____Zip: _____

Cell Phone: _____Email Address: _____

Date of Birth: _____ Sex: _____ Preferred name to be addressed: _____

Social Security Number: _____ Guardian's name if patient is a minor: _____

Emergency Contact: _____Cell Phone: _____

Preferred Pharmacy: _____Pharmacy Phone Number: _____

How did you hear about us? ☐ Radio ☐ Magazine ☐ Mall Ad ☐ Referral_____ ☐ Other_____

Insurance Information

Do you have Dental Insurance? **Yes** **No**

Insurance Company:		Insurance Phone Number:
Subscriber Name:		Relationship to Subscriber:
Subscriber SSN:	Subscriber DOB:	Subscriber Employer:
Insurance ID#		Insurance Group #
Insurance Address:		

Payment, Insurance, and Financial Arrangement Policies

We require payment in full for services rendered at the time of visit if you do not hold dental insurance that is a PPO or higher. We accept Cash, Visa, Discover, American Express, Master Card, and CareCredit. As a courtesy, we will file all primary insurance for you as long as it is a PPO dental plan. We do not file secondary insurance and do not accept discount plans or HMO dental plans. It is your responsibility to present our office with your most current insurance card and information. Failure to do so may cause you to be responsible for the entire account balance. Payment of services, applicable deductibles and co-payments are due at time of your visit. We will estimate the portion to be covered by your insurance and your financial obligation for each dental procedure. This is only an *estimate* until the claim is paid by your insurance. You are responsible for all amounts not covered by your insurance company. First Pacific Corporation will inform you of any outstanding balances after we receive payment from your insurance with a statement and our office does expect payment within 30 days or we reserve the right to ask an outside collection agency to collect these fees that are your responsibility.

Signature of Patient (or Patient Representative) _____Date: _____

Cancellation Policy

Please notify our front office staff of any appointment cancellations or rescheduled appointments at least 24 hours in advance. Please be aware that there is a **$45 service fee** for all failed or cancelled appointments without a **24 hour notice.** The purpose for this charge is that the appointment time scheduled with the dentist or hygienist was reserved for you. Out of consideration for another patient who may have needed that time, and in respect for the dentist who designated the time for you, this charge may be imposed. We sincerely appreciate you respecting our cancellation policy.

Signature of Patient (or Patient Representative) _____Date: _____

Health Information

Patient's Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone Number: _____

Date of last dental visit: _____ Previous Dentist: _____

Have you ever been treated for periodontal (gum) disease? **Yes No**

Have you taken antibiotics prior to dental procedures in the past? **Yes No** Reason: _____

Is there anything else we should know about your health that is not covered in this form? **Yes No**

Do you have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Rheumatic Fever			Artificial Joint			Psychiatric Treatment		
Heart Murmur			Surgical Prosthesis			Bruise Easily		
Mitral Valve Prolapse			Ulcers/Stomach Problems			Asthma		
Congenital Heart Disease			Cancer (Type_____)			Hay Fever		
Artificial Heart Valve			Kidney Disease			Emphysema		
Pacemaker			Diabetes			Allergies or Hives		
High/Low Blood Pressure			Glaucoma			Sinus Trouble		
Obstructive Sleep Apnea			Transplant (Type_____)			Anemia		
Heart Attack			Scarlet Fever			Cold Sores/Herpes		
Blood Thinning Treatment			Thyroid Disease			Blood Transfusion		
HIV or AIDS			Tuberculosis			Dialysis		
Pain in your jaw (TMJ)			Lung Disease			Use of Tobacco Products		
Hepatitis (Type_____)			Arthritis/Rheumatism			Use of Alcohol		
Liver Disease			Stroke			Use of Illegal IV Drugs		
Venereal Disease			Epilepsy or Seizures			Other:		
Inner Ear Disorder/Surgery			Fainting or Dizzy Spells					

Allergies:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Penicillin			Latex			Epinephrine		
Codeine			Sulfa Drugs			Local Anesthetics		
Aspirin			Other:					

Women Patients Only:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Are you pregnant?			Are you nursing?			Do you take birth control?		

Medications: (List all medications and dietary supplements you have taken in the last 3 months. Include dosage and reason)		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I give my consent to the dentist to perform and examination and diagnose my condition. I also give consent for any preventative or basic restorative procedures which may be necessary. I understand this consent will remain in effect until treatment is terminated either by me or the dentist.

Signature of Patient (or Patient Representative) _____Date: _____

Printed Name of Patient (or Patient Representative) _____Date: _____

Annual Fluoroscopy Screening (Velscope)

During your dental exam with Dr. Osborne, each patient (18 years of age or older) is visually screen for oral cancer, which has been the method of detection for years. Now, we can step up our early detection and increase the chances of survival by utilizing fluoroscopy.

- Oral Cancer kills one person every hour and over 40,000 Americans each year due to late stage discovery.
- It can occur on the lip, tongue, or floor of the mouth. While prevalent among smokers, people who chew tobacco or drink alcoholic beverages, oral cancer can strike anyone.
- HPV (Human Papilloma Virus) has been associated with the occurrence of oral cancer.
- This fast, simple, pain-free, diagnostic procedure can help provide early detection and dramatically increase survival rates.
- We recommend the fluoroscopy screening to be annually to enhance early detection.
- With or without insurance, the cost for the pre-cancer screening is **$20.00.**

☐ **YES,** I do want the Velscope performed annually.
☐ **NO,** I do not want the Velscope performed annually.

Signature of Patient (or Patient Representative) _____Date: _____

Printed Name of Patient (or Patient Representative) _____Date: _____

HIPAA Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

I _____ have received a copy of this office's Notice of Privacy Practices.

Signature of Patient (or Patient Representative) _____Date: _____

Printed Name of Patient (or Patient Representative) _____Date: _____

Authorization for Release of Records to External Parties

I authorize the disclosure of information from my treatment records under the Privacy Act to:

Name of Recipient: _____ Relationship: _____

Name of Recipient: _____ Relationship: _____

I understand that I may withdraw or revoke my permission at any time. To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature of Patient (or Patient Representative) _____Date: _____

Printed Name of Patient (or Patient Representative) _____Date: _____

HIPAA Notice of Privacy Practices

Revised to reflect the 2013 HIPAA/HITECH Omnibus Final Rule

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully. If you have any questions about this Notice, please contact Dr. Jeffrey Osborne: 972-335-9313.
This Notice is effective on September 26, 2013

OUR COMMITTEMENT REGARDING YOUR PERSONAL HEALTH INFORMATION

Legacy Ranch Dental is committed to maintaining and protecting the confidentiality of our employees' personal information. This Notice of Privacy Practices applies to Legacy Ranch Dental dental plans collectively, the Plans. The Plans are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices. When the Plans use or disclose your PHI, the Plans are bound by the terms of this Notice, or the revised Notice, if applicable.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations 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. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so 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 health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

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 births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or 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 authorized 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 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) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:
1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Dr. Jeffrey Osborne at info@legacyranchdental.com. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

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 Dr. Jeffrey Osborne at info@legacyranchdental.com.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Dr. Jeffrey Osborne at info@legacyranchdental.com.

Right to Request Restrictions. You have the right to request a restriction or 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 your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Dr. Jeffrey Osborne at info@legacyranchdental.com. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Dr. Jeffrey Osborne at info@legacyranchdental.com. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.legacyranchdental.com. To obtain a paper copy of this notice, contact Dr. Jeffrey Osborne at info@legacyranchdental.com.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Jeffrey Osborne at info@legacyranchdental.com. All complaints must be made in writing. You will not be penalized for filing a complaint.

You may contact our office at:
Legacy Ranch Dental
4851 Legacy Drive, Suite 201
Frisco, TX 75034

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all of your PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.