

**FARYL K. HART, DDS**  
2103 E. Parham, Suite 102  
Richmond, VA 23228  
(804) 266-2074

**Insurance**

If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. You will be asked to update your contact information and insurance information periodically, including providing our office with copies of your insurance card(s). Please assist us in complying with your insurance updates.

We will gladly submit fees for your covered dental services to your insurance company. However, we expect payment for all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits. We will gladly assist you to insure all plan requirements are met.

**Payment for services**

Payment for services, including insurance co- payments and deductible amounts, is due at the time of service and are rendered unless payment arrangements have been approved in advanced by our staff. Our failure to collect these amounts may be in violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative.

We accept cash, checks, MasterCard, Visa and Discover. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees.

**Cancelled Appointments**

Charges will be made for broken, confirmed appointments and appointments cancelled without 48 hours advanced notice. Your cooperation in canceling your scheduled appointment well in advance of the appointment allows us the opportunity to offer your appointment to another person who needs dental care. Failure to show for a scheduled confirmed appointment will result in a \$25.00 cancellation fee.

**General**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand, that we only participate with some of dental insurance carriers. Your insurance, however, is a contract between you, your employer and the insurance company. We are, not a party to that contract. We are very sensitive to keeping health cost affordable to our patients. As a result, we take great care to insure that our fees are consistent with the changes in this demographic region.

Not all services are a covered benefit in all contracts. Some companies arbitrarily select services they will not cover. We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

My signature below constitutes acknowledgement and acceptance of this policy.

**Patient's**  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print name** \_\_\_\_\_

# REGISTRATION HISTORY

DATE \_\_\_\_\_

PATIENTS NAME \_\_\_\_\_

SINGLE \_\_\_\_\_  
WIDOWED \_\_\_\_\_  
MARRIED \_\_\_\_\_  
DIVORCED \_\_\_\_\_  
SEPARATED \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_

IF A CHILD, PARENT'S NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PATIENT (OR PARENT) EMPLOYED BY \_\_\_\_\_ PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_ PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

PURPOSE OF THIS APPOINTMENT \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED \_\_\_\_\_ PHONE \_\_\_\_\_

WHO WILL PAY THIS ACCOUNT \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_

IF USING CHARGE CARD, NAME \_\_\_\_\_ CARD NO. \_\_\_\_\_

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? YES \_\_\_\_\_ NO \_\_\_\_\_

IF SO, NAME OF INSURANCE COMPANY \_\_\_\_\_

SUBSCRIBER I.D.# \_\_\_\_\_ GROUP# \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ SUBSCRIBER BIRTH DATE \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

## INSURANCE & PAYMENT POLICIES

OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS AND WE CHARGE WHAT IS USUAL AND CUSTOMARY IN OUR AREA. YOU ARE RESPONSIBLE FOR FULL PAYMENT REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ARISING FROM THE TREATMENT OF MYSELF (OR THE ABOVE PATIENT, IF APPLICABLE).

WE WILL FILE INSURANCE ON THE SAME DAY OF SERVICE AND WILL ALLOW 30 DAYS FOR PAYMENT. AFTER THAT TIME, THE BALANCE BECOMES THE PATIENT'S RESPONSIBILITY AND INTEREST OF 1.5% PER MONTH WILL BE ADDED TO THE UNPAID BALANCE.

IF MY ACCOUNT IS REFERRED TO ANY ATTORNEY FOR COLLECTION, I AGREE TO PAY ALL COURT COSTS, INCLUDING ATTORNEY'S FEES IN THE AMOUNT OF THIRTY-THREE AND ONE-THIRD PERCENT (33 1/3) OF THE TOTAL INDEBTEDNESS THEN DUE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

WE ACCEPT CASH, CHECK, MASTERCARD & VISA

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

- |  |     |    |
|--|-----|----|
| 1. Are you in good health? .....   | Yes | No |
| 2. Has there been any change in your general health within the past year? .....  | Yes | No |
| 3. My last physical examination was on _____   |     |    |
| 4. Are you now under the care of a physician? .....  | Yes | No |
| Yes if so, what is the condition being treated? _____  |     |    |
| 5. The name and address of my physician(s) is _____  |     |    |
| 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? .....  | Yes | No |
| If so, what was the illness or problem? .....  |     |    |
| 7. Are you taking any medicine(s) including non-prescription medicine? .....   |     |    |
| Yes if so, what medicine(s) are you taking? _____  |     |    |
| 8. Do you have or have you had any of the following diseases or problems? .....  |     |    |
| a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease .....  | Yes | No |
| b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... | Yes | No |
| 1. Do you have chest pain upon exertion? .....   | Yes | No |
| 2. Are you ever short of breath after mild exercise or when lying down? .....  | Yes | No |
| 3. Do your ankles swell? .....   | Yes | No |
| 4. Do you have inborn heart defects? .....   | Yes | No |
| 5. Do you have a cardiac pacemaker? .....  | Yes | No |
| c. Allergy .....   | Yes | No |
| d. Sinus trouble .....   | Yes | No |
| e. Asthma or hay fever .....   | Yes | No |
| f. Fainting spells or seizures .....   | Yes | No |
| g. Persistent diarrhea or recent weight loss .....   | Yes | No |
| h. Diabetes .....  | Yes | No |
| i. Hepatitis, jaundice or liver disease .....  | Yes | No |
| j. AIDS or HIV infection .....   | Yes | No |
| k. Thyroid problems .....  | Yes | No |
| l. Respiratory problems, emphysema, bronchitis, etc. ....  | Yes | No |
| m. Arthritis or painful swollen joints .....   | Yes | No |
| n. Stomach ulcer or hyperacidity .....   | Yes | No |
| o. Kidney trouble .....  | Yes | No |
| p. Tuberculosis .....  | Yes | No |
| q. Persistent cough or cough that produces blood .....   | Yes | No |
| r. Persistent swollen glands in neck .....   | Yes | No |
| s. Low blood pressure .....  | Yes | No |
| t. Sexually transmitted disease .....  | Yes | No |
| u. Epilepsy or other neurological disease .....  | Yes | No |
| v. Problems with mental health .....   | Yes | No |
| w. Cancer .....  | Yes | No |
| x. Problems of the Immune System .....   | Yes | No |
| 9. Have you had abnormal bleeding? .....   | Yes | No |
| a. Have you ever required a blood transfusion? .....   | Yes | No |
| 10. Do you have any blood disorder such as anemia? .....   | Yes | No |
| 11. Have you ever had any treatment for a tumor or growth? .....   | Yes | No |
| 12. Are you allergic or have you had a reaction to:  |     |    |
| a. Local anesthetics .....   | Yes | No |
| b. Penicillin or other antibiotics .....   | Yes | No |
| c. Sulfa drugs .....   | Yes | No |
| d. Barbiturates, sedatives, or sleeping pills .....  | Yes | No |
| e. Aspirin .....   | Yes | No |
| f. Iodine .....  | Yes | No |
| g. Codeine or other narcotics .....  | Yes | No |
| h. Other .....   |     |    |
| 13. Have you had any serious trouble associated with any previous dental treatment? .....  | Yes | No |
| If so, explain _____   |     |    |
| 14. Do you have any disease, condition, or problem not listed above that you think I should know about? .....  | Yes | No |
| If so, explain _____   |     |    |

**WOMEN**

- |   |     |    |
|---|-----|----|
| 15. Are you pregnant? .....                   | Yes | No |
| 16. Are you nursing? .....                    | Yes | No |
| 17. Are you taking birth control pills? ..... | Yes | No |

## DENTAL HISTORY

YES      NO

1. Are your teeth sensitive to:  
 Heat? .....         
 Cold? .....         
 Sweets? .....         
 Biting Pressure? .....
2. Does food constantly get stuck between certain teeth in your mouth? .....
3. Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? .....
4. Are you dissatisfied with your teeth in any way? .....
5. Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. ....
6. Do you have any fillings that show in your front teeth? .....
7. Do any of your fillings show when you smile? .....
8. If any of your mercury amalgam fillings need replacement would you prefer to have a more natural tooth-colored restoration instead? .....
9. Have you ever had any teeth removed? .....
10. How long have these teeth been missing? \_\_\_\_\_
11. Do your gums bleed when brushing? .....
12. Do you ever avoid any part of the mouth while brushing? .....
13. Have you been instructed regarding proper home care? .....
14. Do you have an unpleasant taste or odor in your mouth? .....
15. Do you smoke? .....
16. Do you frequently snack between meals on sweets or chew gum? .....
17. How often do you brush your teeth? \_\_\_\_\_
18. How often do you use floss? \_\_\_\_\_
19. Do you want to learn to control dental disease and retain your teeth? .....
20. Has the fear of discomfort kept you from regular dental visits? .....
21. Are you deeply concerned about the finances required to return your mouth to excellent dental health? .....
22. When was your last dental appointment? \_\_\_\_\_
23. What did you have done? \_\_\_\_\_
24. How long since your last *thorough* examination with *full mouth x-rays*? \_\_\_\_\_
25. What prompted you to seek dental care at this time? \_\_\_\_\_

REMARKS:

# **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.**

This notice takes effect on \_\_\_\_\_ and remains in effect until we replace it.

## **1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

## **2. OUR LEGAL DUTY**

### ***Law Requires Us to:***

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

### ***We Have the Right to:***

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

### ***Notice of Change to Privacy Practices:***

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

## **3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

**Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical 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 share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

**Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

**Appointment Reminders:** We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

**Alternative and Additional Medical Services:** We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

#### 4. YOUR INDIVIDUAL RIGHTS

##### **You Have a Right to:**

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$\_\_\_\_\_ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

**QUESTIONS AND COMPLAINTS**

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

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We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

**Facility Directory:** Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

**Notification:** We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

**Disaster Relief:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Fundraising:** We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

**Research in Limited Circumstances:** We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

**Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

# PRIVACY PRACTICES ACKNOWLEDGEMENT

## ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

12/11/03