Lawrence O Sims, DDS
Prosthodontist

# *NEW PATIENT INFORMATION*

Patient's Name _____
Last First MI

____Male ____Female ____Married ____Single ____Other

Social Security #_____-___-_____ Birthdate____/____/____

Phone (home)_____ (cell)_____

(work)_____ (other)_____

Address

_____
House# Street Apt or Unit

_____
City State Zip code

E-mail address_____

Date and reason of your last dental visit_____

Whom may we thank for referring you_____

Have you ever had any of the following conditions? Please circle all those that apply:

| | |
|---|---|
| AIDS/HIV Positive | Heart Murmur |
| Allergies | Hepatitis A,B,C |
| Anemia | High Blood pressure |
| Arthritis | Kidney Disease |
| Blood decrease | Mental Disorders |
| Cancer | Nervous Disorders |
| Codeine allergy | Pacemaker |
| Diabetes | Pregnancy |
| Dizziness | Radiation treatment |
| Epilepsy | Respiratory problems |
| Jaundice | Rheumatic Fever |
| Liver Disease | Sinus problems |
| Excessive bleeding | Stroke |
| Fainting | Tuberculosis |
| Glaucoma | Joint replacement |
| Tumors | Hay fever |
| Ulcers | Head injuries |
| Heart disease | Venereal disease |
| Other | |

Have you ever had any complications following dental treatment? _____Yes _____No

If yes, please explain_____

Have you been hospitalized or needed emergency care during the past two years? _____Yes _____No

If yes, please explain_____

Are you under the care of a physician? _____

If yes, please explain_____

Name and telephone number of treating physician

_____ _____

Do you need to take antibiotics or any specific medications prior to your dental visit? _____

If yes, please explain_____

If you are aware of any health problems requiring further clarification, please explain:

_____

_____

If you have allergies, please list them:_____

Please list all medications and supplements you are taking on the next page or attach a list to this form.

If you are to take medication prior to a dental appointment, have you taken it today? _____

*To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have a change in my health status, I will inform the doctor before the next appointment without fail.*

Patient Name_____ Date_____

Signature_____

(If applicable)
Name of person filling out this form_____

Relationship to the patient_____

## Medications

Your name (please print) _____ Date _____

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## Responsible Party Information

Please provide information about the person who will be responsible for the financial aspects of your treatment if other than yourself:

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

____Male ____Female ____Married ____Single ____Other

**Social Security #**_____-___-_____ Birthdate____/____/____

**Phone** (home)_____ (cell)_____ (work)_____

**Address**

_____

House# Street Apt or Unit

_____

City State Zip code

## Employment Information

Employer name_____ Occupation_____

Address_____
Street City Zip code

## Insurance Information [Please also read and complete page 7 if this section is completed]

Primary name of insured_____ Insurance carrier_____

Insured's Date of Birth_____ ID#_____ Group #_____

Insured Address_____
Street City Zip code

Patient's relationship to insured Self____ Spouse____ Child____ Other_____

**CONSENT FOR SERVICES**

I understand that payment in full is due at the time of treatment unless prior arrangements are made. I authorize the dental staff to perform the necessary dental services for my treatment and/or diagnosis.

Signature of Patient _____ Date_____
(or Parent if Patient is a Minor)

# Appointment and Financial Guidelines

We believe our patients want to know and understand our appointment and financial guidelines in advance of treatment. We are always happy to discuss this with you.

## APPOINTMENT GUIDELINES

We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved which means that other patients will have to select another time for treatment. When time is lost due to last minute cancellations, your treatment is delayed and we often cannot schedule another patient to be seen. While we understand that emergencies do occur, we may charge a $50 cancellation fee for appointments cancelled less than 36 hours in advance.

We consider all appointments confirmed when they are made. Although we will make every effort to remind patients by telephone, email or text prior to their appointments, we have found that some patients may not receive these reminders. Therefore, the appointment is confirmed when made and implies your obligation to be present at that pre-arranged date and time.

By signing below, you agree that you understand and agree to these appointment guidelines.

## FINANCIAL GUIDELINES

We accept Cash Check, American Express, Visa, MasterCard and Discover for payment. Payment of fees is due on the date of treatment unless previously discussed and arranged. Payment for a dental restoration is due when the treatment is planned.

I understand and accept these appointment and financial guidelines

Signature_____ Date_____

# Insurance Guidelines [Complete only if providing dental insurance information]

We will file your insurance claim by mail or electronically after each visit to assure your reimbursement. You should be aware that your dental coverage was issued without any form of examination of your oral health or any input from you. Your insurance company has no knowledge of your dental condition or of any preferences you have regarding your treatment. Our agreement is with you and not with your insurance company. We feel this allows our practice to provide the highest level of care. While you are financially responsible for the services you will receive, we will be happy to assist you by filing claims and by answering your questions. We are a fee-for-service provider which means that we are not "in network" for any company and that we do not accept assignment of your benefits.

Your Responsibilities will be:

1. To pay all fees at the time of treatment or as otherwise arranged
2. To provide our office with necessary information concerning your insurance coverage if you wish for us to assist you in filing claims
3. To understand that any insurance coverage or dental assistance coverage you have is a contract between you and your employer and the insurance carrier. While we will make all reasonable efforts to facilitate claims payments, we do not have the power to force an insurance company to pay.

We will:

1. Complete insurance claim forms and submit to your carrier within 48 hours of your treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Provide you with the necessary documents you may need to contact your carrier regarding your claim.
4. Refund any payment from your insurance company incorrectly mailed to our practice instead of to you.

Thank you for choosing us for your dental needs. Please know that we appreciate your trust in us and that we will do as much as possible to ensure you receive the full benefits of your insurance coverage.

*I, (please print name) _____, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office and that I will be reimbursed directly from my insurance carrier. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.*

Signature (Patient or Insured)_____ Date_____

Dental Office Representative_____ Date_____

# Lawrence O. Sims, DDS
# 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.**

### I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Lawrence O. Sims, DDS ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

### II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Lawrence O. Sims's Privacy Official at:

7000 Peachtree Dunwoody Road, Building 12, Suite 100, Sandy Springs, GA 30328

770-623-9241

info@doctorsims.com

### III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

### IV. Last Revision Date

This Notice was last revised on November 17, 2016

### V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

### A. Common Uses and Disclosures

**1. Treatment.** We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

**2. Payment.** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

**3. Health Care Operations.** We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training,

evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

**4. Appointment Reminders.** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

**5. Treatment Alternatives and Health-Related Benefits and Services.** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

**6. Disclosure to Family Members and Friends.** We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

**7. Disclosure to Business Associates.** We may disclose your protected health information to our third-party service providers (called, "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 a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**B. Less Common Uses and Disclosures**

**1. Disclosures Required by Law.** We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

**2. Public Health Activities.** We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**3. Victims of Abuse, Neglect or Domestic Violence.** We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

**4. Health Oversight Activities.** We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

**5. Lawsuits and Legal Actions.** We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

**6. Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

**7. Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

**8. Organ, Eye and Tissue Donation.** We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

**9. Research Purposes.** We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

**10. Serious Threat to Health or Safety.** We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

**11. Specialized Government Functions.** We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

**12. Workers' Compensation.** We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

### VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

### VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

### A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

### B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

### C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

### D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

### E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each

subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

**F. 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 paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

**G. Right to Receive Notification of a Security Breach**

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

**VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information**

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

**IX. Our Right to Change Our Privacy Practices and This Notice**

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is November 17, 2016.

**X. How to Make Privacy Complaints**

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

**ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of Lawrence O, Sims, DDS Notice of Privacy Practices effective November 17, 2016.

Name (please print): _____

Signature: _____ Date:_____

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I am a parent or legal guardian of _____ (patient name). I have received a copy of Lawrence O. Sims, DDS Notice of Privacy Practices effective November 17, 2016.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

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If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective November 17, 2016 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____