301 Hospital Rd • Starkville, MS 39759
(662)323-3245 • www.StarkvilleSmiles.com

FAMILY DENTISTRY • COMMITTED TO EXCELLENCE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple heathcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent, I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

Barry W. Herring, D.M.D./Jonathan A. Woolfolk D.M.D.
301 Hospital Road, Starkville, MS 39759
Phone: 662-323-3245; Fax 662-323-6004

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____

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Patient Name: ____

Whom may we thank for referring you to our office? ______________________

Have you been hospitalized during the past 2 years? ______________________

Are you currently under the care of a physician? Yes____ No ____
Physician's Name: ____

Have you ever had? (Answer Yes or No):

Abnormal bleeding	______	Heart Disease	______
Adrenal disorder	______	Heart Murmur	______
AIDS or related complex	______	Heart Pacemaker	______
Allergies to metal, jewelry	______	Hepatitis	______
Arthritis	______	HPV	______
Artificial Heart Valve	______	Kidney Disease	______
Artificial Joint (s)	______	Latex Allergy	______
Asthma	______	Liver Disease	______
Cancer Therapy	______	Lung Disease	______
Convulsions/Seizures	______	Lupus	______
Allergic to chocolate/nuts	______	Mitral Valve Prolapse	______
Diabetes	______	Emphysema	______
Rheumatic Fever	______	Thyroid Disorder	______
Grinding Teeth	______	Stroke	______
Low Blood Pressure	______	Thumb Sucking Habit	______
High Blood Pressure	______	Multiple Sclerosis	______

During your sleep, do you:

- Snore ______ - Choke or gasp during sleep _____
- Wake frequently ______ - Feel tired or fatigued ______
- Have you had a sleep study or been prescribed a CPAP ______

Do you use any of the following products:

- Cigarettes_____ Smokeless Tobacco____ Vape/E-Cig____
- Chewing Tobacco_____

Are you taking any medicines now? YES NO

If yes, list them: ____

Preferred Pharmacy: ____

Are you allergic to any medicines? YES NO

If yes, list them: ____

WOMEN: Are you pregnant? YES NO

The medical information I have provided is true and accurate to the best of my knowledge.

Signed ______________________________________Date______________________

<u>Payment Options</u>

Thank you for choosing us to provide your dental care. We believe you will find that we want to work with you in arranging for payment of our services. In that effort we have provided several options, one of which should fit your needs. Please ask at the front desk for any fee information you need at any time and <u>please stop there after each appointment</u> to handle your bill.

<u>Insured Patients</u>

If you have insurance, we will enter that information in your record and file that claim at no extra charge. Patients are asked to pay for the part their insurance will not pay on the **<u>day of their appointment.</u>** We accept most insurances except for Medicaid, Medicare, or Ambetter and if you are part of a network, we will still file your insurance. Some insurance companies send payments to us and some send payment to the patient. Your information and our experience with your company will help us estimate how much your portion will be. These bills are due upon receipt**.** We do our best to provide you with the most accurate insurance coverage information, but ultimately **insurance coverage, insurance payments, and general insurance questions are between the patient and the insurance company. <u>It is the patient's responsibility to be well-versed in their dental insurance coverage.</u>**

**We understand that insurances can be frustrating and delay payment for miscellaneous reasons. As a courtesy, we will be involved in working with insurances for payment for up to 6 months past the date of service. After this time, the balance owed by insurance will be dropped to patient.

<u>Non-insured patients</u>

Patients who do not have insurance must pay in full or make acceptable arrangements for services at the time of the service. (See "How to Pay" below).

<u>Methods of payment</u>

- A 7% discount is given to patients without insurance when the treatment is paid in full on the **date of service** with <u>CASH</u> or <u>CHECK</u>**.**
- MasterCard, Visa, American Express or Discover
- Care Credit

*******I have read this Payment Policy and understand my payment responsibilities, and that all payments are due on the date of service.**

Print Name: ______________________________ Signature: ______________________________

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Patient Legal Name: ___________________________________ Goes by: _______________
First Middle Last
Address: ___________________________________ **APT#** _____________City ____________

State ________Zip_____________ **E-mail-Address**:____________________________________

Phone (H) ______________(Cell) _____________(W1)______________(W2)____________

D.O.B. ____/____/___________Sex (m)______ (f) _____ Marital: (s) ___(m)___(d)___(w)___

S. S. N. (for identification purposes) _____-_____-___________
Full Time Student (yes or no): ______________________________

FOR DENTAL INSURED PATIENTS

Policy Holder's Name:__________________________________ Relation to patient__________

D.O.B. ______/______/__________ SSN _____________________ Phone ________________

Address (if different than patient's) ____

Employer______________________________Insurance Co. ____________________________

ID # ______________________ Group # ________________ INS phone # _________________

Insurance Address____

RESPONSIBLE PARTY (Responsible for balance due)

Name: _______________________________ D.O.B:______________________________

SSN: ___________________Relation to Patient: ________________________________

Address (if different than patients'): ____

City: _________________________State: ___________________ Zip: ______________

Phone #: _______________________ Email Address: _____________________________

(Please READ the following CAREFULLY and make sure you understand)

*****As of January 1st, 2022, we have made changes to our appointment policy. If you do not confirm your appointment within 24 hours of your appointment time we will not be able to reserve you appointment and your appointment will be canceled. This is to best serve you and our other patients. Please sign below to indicate you understand our appointment confirmation policy.**

Signed _____________________________________ **Date**____________________