Welcome to the Orthodontic Office of Thomas M. Skafidas, D.M.D.

We are pleased to have you as a new patient and hope that this letter will enable you to become familiar with our procedures.

Preliminary Examination
The initial appointment is a clinical examination to determine your orthodontic needs. We will advice you of any problem and the necessary corrective treatment. If a fee for this examination is charged, it will be $55.00 - $95.00. If diagnosis records are made, any examination fee previously charged is applied toward that cost, if the records are done within six (6) months of the initial exam date.

Diagnostic Records
If treatment is indicated, records will be taken to enable the doctor to study the problems and determine the corrective procedures. We will take impressions for upper and lower study models, facial and oral photographs, a panoramic and cephlometric head x-ray. The fee for diagnostic records is separate from the fee for any orthodontic treatment that may be required.

Consultation
Both parents (if a minor) and the patient are requested to attend. We will discuss the specific problem(s) as well as our plan of treatment. The fee for the entire treatment, its anticipated length and financial arrangements will be discussed.

Insurance
Insurance companies vary greatly in the amount of coverage and method of payment for orthodontic treatment. We will be happy to assist you in submitting the necessary insurance forms to your carrier, so you will be promptly reimbursed.

Family Dentist
You must have your teeth cleaned and all cavities filled before your orthodontic treatment can begin. We recommend that you continue to be seen every six months during treatment for cleaning and cavity checks by your family dentist. For their use, your dentist may take additional x-rays.

Our Appointments
For our child patients, it will be necessary to make some appointments during school hours. Every attempt will be made to keep these to a minimum.

We look forward to working with you and welcome any questions that you may have.

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entitles that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one to more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives to other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 healthcare 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 received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 above to obtain a current copy of the Notice of Privacy Practices.

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.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Please fill out these forms completely.
The better we communicate, the better we can care for you.

About You

Today's Date: _____
Name: _____
I prefer to be called: _____
Birth date: ____/____/_____ Age: _____
SS#:_____
Home Address: _____
_____
CITY STATE ZIP
Single Married Divorced Widowed Separated
Home#: _____ Pager/Other #: _____
WK#: _____ Ext: _____
Employer: _____
Employer's Address: _____
How Long There? _____Occupation: _____
Where & when are the best times to reach you? _____
Whom may we Thank for referring you? _____
Other family members seen by us: _____
General Dentist: _____
General Dentist Phn#: _____
Last visit date: _____

Spouse Information

His/Her Name: _____
Employer: _____
WK#: _____ Ext: _____ SSN#:_____
Birth date: _____

Person Responsible for Account: _____
WK#: _____ Ext: _____SSN#_____
Billing Address: _____
Relationship: _____ SSN#: _____
Employer: _____

Medical History
Do you have a personal physician? Y N
Physician's Name_____
Phone#: _____
Date of Last Visit: _____

Orthodontic Insurance

Primary

Orthodontic Coverage Y N
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone#: _____
Group# (Plan, Local, or Policy#):
_____

Insured's Name: _____
Insured's Birthday: ____/____/____
Insured's SSN#: _____
Insured's Employer:
_____

Orthodontic Insurance
Secondary
Orthodontic Coverage Y N
Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Phone#: _____
Group# (Plan, Local, or Policy#):
Insured's Name: _____
Insured's Birthday: ____/____/____
Insured's SSN#: _____
Insured's Employer:
_____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____
Relation: _____
WK#: _____
HM#: _____

Your current physical condition is
[] Good [] Fair [] Poor

Are you currently under the care of a physician?
[] Yes [] No
Please explain: _____

Are you taking any prescription / over-the-counter drugs?
[] Yes [] No Please list each one _____
_____

Have you ever had any of the following diseases or medical problems?

Y N	Heart Attack / Stroke	Y N	Psychiatric Problems
Y N	Cancer/Chemotherapy	Y N	Epilepsy/ Seizures/ Fainting Spells
Y N	Heart Murmur	Y N	Diabetes/ TB
Y N	Rheumatic Fever	Y N	Drug/ Alcohol Abuse
Y N	HIV+ / AIDS	Y N	Venereal Disease
Y N	Heart Surgery/Pacemaker	Y N	Hemophilia/Abnormal Bleeding
Y N	Shingles	Y N	Ulcers/ Colitis
Y N	Mitral Valve Prolapse	Y N	Congenital Heart Defect
Y N	Kidney Problems	Y N	Anemia/ Radiation Treatment
Y N	Artificial Bones/ Joints	Y N	Asthma/ Arthritis
Y N	Artificial Valves	Y N	Difficulty Breathing
Y N	Sinus Problems	Y N	Hospitalized for Any Reason
Y N	High/Low Blood Pressure	Y N	Hepatitis
Y N	Fever Blisters	Y N	Blood Transfusion
Y N	Severe/ Frequent Headaches	Y N	Emphysema/Glaucoma

Please list any medical condition (s) that you have ever had:
_____

Are you allergic to any of the following items?

Y N	Penicillin	Y N	Tetracycline	Y N	Latex
Y N	Aspirin	Y N	Dental Anesthetics	Y N	Any Metal/Plastic
Y N	Erythromycin	Y N	Codeine	Y N	Other

Please list any other drugs that you are allergic to: _____
_____

MEDICAL HISTORY UPDATES

Initials _____ Date_____
Initials _____ Date_____

Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____
_____

Have you ever been evaluated for orthodontic treatment?
[] Yes [] No
Have you ever had a serious/ difficult problem associated with any previous dental work? [] Yes [] No
Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? [] Yes [] No

Your current dental health is [] Good [] Fair [] Poor
Do you like your smile? [] Yes []No
Do your gums ever bleed? [] Yes [] No
(Please Circle)
Have you ever had an injury to your: Mouth Teeth Chin
Do you have any speech problems? _____
_____
(Please Circle One)
Do you generally breathe through your mouth? Yes No
Awake? Yes No Asleep? Yes No
Do you have any missing or extra permanent teeth?[]Y []N
IF YOU HAVE ANY ADDITIONAL QUESTIONS OR CONCERNS, PLEASE DESCRIBE: _____
_____
_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____
Signature Date

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential Patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

TRANSFER PATIENTS ONLY:
I hereby authorize transfer of my records to

THOMAS M. SKAFIDAS, D.M.D

_____
Signature Date

INSURANCE LETTER

IF YOU HAVE ORTHODONTIC OR DENTAL INSURANCE, PLEASE FILL OUT THE HIGHLIGHTED PORTIONS ON THE ENCLOSED UNIVERSAL INSURANCE FORM, SIGN, BUT DO NOT DATE THE FORM. PLEASE RERURN THIS FORM AT THE INITIAL EXAMINATION APPOINTMENT, ALONG WITH THE ENCLOSED HEALTH HISTORY FORM.

OUR OFFICE WILL FILE THE PAPER WORK FOR YOU, SI THE INSURANCE COMPANY (IF YOU HAVE APPLICABLE COVERAGE UNDER YOUR POLICY) WILL REIMBURSE YOU DIRECTLY. OUR OFFICE DOES NOT ACCEPT ASSIGNMENT (PAYMENT FROM THE INSURANCE CARRIERS). WE REQUEST THAT YOU REMIT FOR SERVICES RENDERED, AND WE WILL FILE FOR THE INSURANCE COMPANY TO PAY YOU DIRECTLY.

PLEASE MAKE SURE THAT ALL APPLICABLE INFORMATION FOR INSURANCE FILING IS CORRECT AND COMPLETE. MEDICAL INSURANCE POLICIES DO NOT COVER ORTHODONTIC SERVICES. WE CAN ONLY FILE ONCE THE APPROPRIATE INSURANCE INFORMATION IS COMPLETE.

OFFICE HOURS

Dear Patients,

In order to better serve our patients, we have established the following office hours. These hours are a result of reviewing patient requests and analyzing appointment times most used, and times when appointments are most often changed or cancelled. Our office hours are as follows:

Monday: **7:00 am to 4:00 pm (last appointment 3:00 pm)**

Tuesday: **7:00 am to 4:00 pm (last appointment 3:00 pm)**

Wednesday: **7:00 am to 4:00 pm (last appointment 3:00 pm)**

Thursday: **7:00 am to 4:00 pm (last appointment 3:00 pm)**

Last morning appointment Monday through Thursday is 12:00 P.M.

Friday: **7:00 am to 2:00 pm (last appointment 11:00 A.M.)**
(One Friday per Month)

Lunch Time: Closed from 12:45 pm to 2:00 pm daily

ALL PATIENTS (ADULT AND CHILDREN) ARE REQUIRED TO FOLLOW A SCHEDULE ROTATION TO ALLOW EVERYONE FAIR ACCESS TO EARLY MORNING AND AFTERNOON APPOINTMENT.

The following appointments are done in the **MORNING HOURS** **or** **NO LATER THAN 2:00 PM,** due to the length of time needed to complete these procedures:

New Patient Exams
Consultations
Diagnostic Records
Impressions
Appointments to repair/replace band or brackets
Splint Fabrication/Adjustments
Bandings & De-Bandings

We appreciate your cooperation

TO OUR PATIENTS:

OUR OFFICE REALIZES THE VALUE OF YOUR TIME. FOR THIS REASON, WE REQUEST THAT CELL PHONES PAGERS AND ALL OTHER ELECTRONIC DEVICES BE TURNED OFF ONCE YOU ARE BROUGHT TO THE TREATMENT AREA.

CELLS PHONES MAY BE USED IN THE RECEPTION ROOM.

THANK YOU FOR YOUR COOPERATION