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:

We would like to welcome you and your child to our office.
Our goal is to make every child's visit pleasant and educational.
We strive to teach good oral care that will enable your child to have
a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date: ________________
Child's Name: ____________________________
Nickname: _______________________________
Birthdate: ____/___ _/_____ Child's Age: _______
School: ___________________________________
Hobbies/Sports: ____________________________
Child's Home#: ____________________________
Child's Home Address: ______________________
____
CITY STATE ZIP

Who is Accompanying Your Child Today?

Name: ____________ Relation: ________________
Do you have legal custody of this child? Y N
Is the patient adopted? Y N
Whom may we thank for referring you? __________
List brothers/sisters w/Age_____________________
____
____

General Dentist: ____________________________
General Dentist Phn#: _______________________
Last Visit Date: ____________________________

Primary Orthodontic Insurance

Orthodontic Coverage [] Yes [] No
Insurance Co. Name: _______________________
Insurance Co. Address: _____________________
Insurance Co. Phone#: _____________________
Group# (Plan, Local, or Policy#):
____

Insured's Name: ___________________________
Relationship to Patient: ____________________
Insured's Birthday: ___/___/____
SSN#:______________________
Insured's Employer: _________________________

Secondary Orthodontic Insurance

Orthodontic Coverage [] Yes [] No
Insurance Co Name: ________________________
Insurance Co. Address: _____________________
Insurance Co. Phone#:___________________
Group# (Plan, Local, or Policy#):
____

Insured's Name: _____________________________

Relationship to Patient: _____________________
Insured's Birthday: ____/____/____
SSN#:________________________
Insured's Employer: _________________________

Parent's Marital Status: [] Single [] Widowed [] Married [] Divorced [] Separated

Mother's Information: [] Step Mother [] Guardian
Name: ____
WK#: _____________ Ext: _______ HM#: ____________
Employer: ____
SS#: ____

Father's Information: [] Step Father [] Guardian
Name: ____
WK#: _____________ Ext: _______ HM#: ____________
Employer: ____
SS#: ____

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

____

____

Has your child ever been evaluated or had orthodontic treatment before?
[] Yes [] No

Have there been any injuries to the face, mouth, teeth or chin?
[] Yes [] No

List any musical instruments played: ______________________

Have adenoids or tonsils been removed? [] Yes [] No

Has your child been informed of any missing or extra permanent teeth?
[] Yes [] No

Has your child ever had any pain/tenderness in his jaw joint?
(TMJ/TMD)? [] Yes [] No

Does your child brush his/her teeth daily? [] Yes [] No

Floss his/her teeth daily? [] Yes [] No

Child's Physician: ____________________________

Phone#: _______________ Date of Last Visit: _________

Is your child currently under the care of a physician: [] Y [] N

Has puberty begun? [] Yes [] No

Has menstruation begun? (Girls) [] Yes [] No

Please describe your child's current physical health:
[] Good [] Fair [] Poor

Please list all medications that your child is currently taking:

____

____

Please list all drugs that your child is allergic to:

____

PATIENT'S REACTION TO ORTHODONTIC TREATMENT IS:
[] Eager [] Complacent [] Antagonistic

PATIENT'S PROGRESS IN SCHOOL:
[] above average [] average [] having difficulty

ARE YOU AWARE THAT SOME APPOINTMENTS WILL INFRINGE UPON SCHOOL TIME? [] YES [] NO

Has your child ever had any of the Following medical problems?

Y N Allergic to Plastic	Y N Allergic to Latex/Metals
Y N Heart Murmur	Y N Congenital Heart Defect
Y N Cancer	Y N Convulsions /Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheumatic Fever	Y N Hearing Impairment
Y N HIV +/ AIDS	Y N Any Operations
Y N Hemophilia	Y N Any stays in a hospital
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Handicaps/ Disabilities
Y N Tuberculosis	Y N Allergies to any Drugs
Y N Mono	Y N Cleft Lip or Palate
Y N Arthritis	Y N Emotional Problems
Y N Thyroid	Y N Endocrine Problems
Y N Cerebral Palsy	Y N Nutritional Problems
Y N Bone Disorder	Y N Fainting or Dizziness

Please discuss any medical problems that your child has had:

____

____

____

Does your child have any of the following:

Y N Thumb/Finger sucking	Y N Mouth Breather
Y N Lip Sucking/ Biting	Y N Speech Problems
Y N Clenching/Grinding Teeth	Y N Nail Biting
Y N Nursing bottle habits	Y N Tongue Thrust

____

MEDICAL HISTORY UPDATES

Initials: ____________ Date_______

Initials: ____________ Date_______

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

I also authorize the orthodontic staff to perform the necessary dental services my child may need.

____
Signature of Parent or Guardian

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 of Parent or Guardian

THE SCHOOL RULE

We would like to familiarize you with our scheduling procedures. Our office has a large number of adult patients; however, the majority of our patients are of school age. Therefore, it is impossible for us to see all our patients during, before or after school hours. **For this reason, we must schedule the lengthy appointments, i.e. appliance placement, removals, impressions, diagnostic records, broken or loose appliances, during the early to mid morning hours, or no later than 2:00 PM**. We reserve the later afternoon times for shorter appointments, such as routine adjustments, retainers adjustments, etc.

If your child has broken or loose appliances, bands, wires, or brackets, we ask that you please call our office in advance, even if the appointment is on the same or next day to let us know of the problem. This will allow us to have the appropriate instrument set-up ready for your child when he/she arrives at the office to prevent any unnecessary delays. This will allow you to avoid any unnecessary waiting.

Orthodontic appointments vary from two (2) to six (6) week intervals. We schedule the appointments as follows: **IF YOU HAVE A BEFORE OR AFTER SCHOOL APPOINTMENT ONE MONTH, THE NEXT MONTH THE APPOINTMENT WILL BE SCHEDULED DURING ANOTHER TIME SLOT**. This is done so that everyone has fair access to "before and after" school appointment times.

Our office will make every reasonable attempt to accommodate your requests for appointments; however, this may not always be possible. **We suggest that when your child comes in for their orthodontic appointment, in order to optimize our ability to better accommodate your schedule, you may wish to go ahead and schedule their appointment for the next month.**

Because the majority of patients are seen on a regular monthly basis, we can only schedule appointments for one month at a time. The only exception to this routine is to coordinate cleaning appointments. We do request that you let us know several weeks in advance when the cleaning appointment is scheduled with your general dentist, or we will be happy to coordinate the appointment with your dentist when you are in our office so as to minimize any scheduling conflicts.

Our goal is to provide quality, professional orthodontic care for your child, in a friendly, relaxed atmosphere and to maintain a schedule that acknowledges the value of your time.

I AM AWARE THAT SOME APPOINTMENTS WILL INFRINGE UPON SCHOOL TIME:

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