PATIENT INFORMATION

Date:_____

Print Patient Name:_____

DOB:_____ Sex: _____M _____F

Home #:_____ Cell #:_____

Email:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Patient Employer/School:_____

Occupation:_____

Marital status: ____Single ____Married ____Divorced

____Separated ____Widowed ____Partnered

Spouse Name:_____

Spouse DOB:_____

IN CASE OF EMERGENCY, CONTACT:

Name:_____

Cell #:_____ Relationship:_____

Whom may we thank for referring you?_____

DENTAL INSURANCE

Who is responsible for this account:_____

Primary Insurance Co:_____

Policy Holder:_____

DOB:_____ Relationship to Patient:_____

Member ID:_____ Group #:_____

Secondary Insurance Co:_____

Policy Holder:_____

DOB:_____ Relationship to Patient:_____

Member ID:_____ Group #:_____

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. George Harouni DDS all insurance benefits if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services. The consent will end when I request in writing the cancellation for authorization of Dr. George Harouni DDS from billing my insurance.

Signature of Patient/Guardian:_____

Print Patient/Guardian Name:_____

Date:_____

Cancellation Policy **Initial:_____**

To ensure that every patient gets individualized attention, scheduled dedicated time is reserved for each appointment. If you need to cancel an appointment, we kindly ask that you provide our office with at least 24 hours notice. Except for emergency situations, missing or cancelling an appointment with inadequate notice may result in a $25.00 fee assessed to your account.

Financial Responsibility Policy **Initial:_____**

Insurance: As a courtesy to our patients our office verifies insurance eligibility and benefits for all patients prior to the date of service. DISCLAIMER: All insurance eligibility provided by provider is not a guarantee of coverage and/or payment by insurance. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service. It is the responsibility of the patient to verify plan participation and coverage with their employer and/or insurance provider prior to receiving dental care services. Any outstanding balance after insurance payment is received is the sole responsibility of the patient.

Payment options **Initial:_____**

Cash, personal checks (subject to $50.00 returned check fee), all major credit cards and outside financing (options available in office). Patient hereby guarantees payment of all charges incurred on the account. Insurance may not cover the full amount charged and patient may be responsible for any accrued balances after insurance payments. Balances not paid in a timely manner are subject to additional charges and/or collection measures.

Dental Consent/Changes in Treatment Plan **Initial:_____**

Patient has completed a health history form and shall be responsible for notifying the office of any changes in patient's medical history. Patient understands that during treatment it may be necessary to change and/or add procedures because of conditions found while working on teeth that were not discovered during the initial examination. Patient shall be informed of all changes to the treatment plan prior to commencement of the treatment. Patient grants permission to the dentist to make any/all changes and additions as necessary for the treatment. If there is no insurance coverage available, Patient is responsible for all charges incurred at the time of service.

I have had the full opportunity to read and consider the contents of this consent form and your HIPAA Notice of Privacy of Patient Consent Form. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Print Patient Name:_____ **Parent/Guardian Name:_____**

Patient or Guardian Signature:_____ **Date:_____**

This Agreement can be signed online or digitally and shall be effective upon the date specified in the Agreement.

Print Patient Name: _____ **DOB**:_____

Place a mark on "yes" or "no" to indicate if you have any of the following:

AIDS/HIV	___ Yes ___ No	Epilepsy	___ Yes ___ No	Respiratory Disease	___ Yes ___ No
Anemia	___ Yes ___ No	Fainting/dizziness	___ Yes ___ No	Rheumatic Fever	___ Yes ___ No
Arthritis, Rheumatism	___ Yes ___ No	Glaucoma	___ Yes ___ No	Scarlet Fever	___ Yes ___ No
Artificial Heart Valve	___ Yes ___ No	Headaches	___ Yes ___ No	Shortness of Breath	___ Yes ___ No
Artificial Joints	___ Yes ___ No	Heart Murmur	___ Yes ___ No	Sinus Trouble	___ Yes ___ No
Asthma	___ Yes ___ No	Heart Problems	___ Yes ___ No	Skin Rash	___ Yes ___ No
Back Problems	___ Yes ___ No	Hepatitis Type ____	___ Yes ___ No	Special Diet	___ Yes ___ No
Bleeding Abnormally with extractions or surgery	___ Yes ___ No	Herpes	___ Yes ___ No	Stroke	___ Yes ___ No
		High Blood Pressure	___ Yes ___ No	Swollen feet or Ankle	___ Yes ___ No
Blood Disease	___ Yes ___ No	Jaundice	___ Yes ___ No	Swollen Neck Glands	___ Yes ___ No
Cancer	___ Yes ___ No	Jaw Pain	___ Yes ___ No	Thyroid Problems	___ Yes ___ No
Chemical Dependency	___ Yes ___ No	Kidney Disease	___ Yes ___ No	Tonsilitis	___ Yes ___ No
Chemotherapy	___ Yes ___ No	Liver Disease	___ Yes ___ No	Tuberculosis	___ Yes ___ No
Circulatory Problems	___ Yes ___ No	Low Blood Pressure	___ Yes ___ No	Tumor or growth head or neck	___ Yes ___ No
Congenital Heart Lesions	___ Yes ___ No	Mitral Valve Prolapse	___ Yes ___ No		
Cortisone Treatments	___ Yes ___ No	Nervous Problems	___ Yes ___ No	Ulcer	___ Yes ___ No
Cough, persistent/blood	___ Yes ___ No	Pacemaker	___ Yes ___ No	Venereal Disease	___ Yes ___ No
Diabetes	___ Yes ___ No	Psychiatric Care	___ Yes ___ No	Weight Loss, unexplained	___ Yes ___ No
Emphysema	___ Yes ___ No	Radiation Treatment	___ Yes ___ No		

Women:

Are you pregnant? ___ Yes ___ No Due Date: _____ Are you nursing? ___ Yes ___ No Taking birth control pills? ___ Yes ___ No

MEDICATIONS:

List any medications you are currently taking:

_____

_____

Pharmacy name and address:_____

Pharmacy phone #:_____

ALLERGIES:

___ Aspirin ___ Local Anesthetic

___ Barbiturates (sleeping pills) ___ Penicillin

___ Codeine ___ Sulfa

___ Iodine ___ Other:

___ Latex _____

SIGN: _____ **DATE**: _____ **Doctor Signature**:_____

UPDATES: (to be completed at future visits)

Have there been any changes to your health history since your last visit? ___ Yes ___ No

For what conditions? _____

Are you taking any new medications? ___ Yes ___ No If so, what? _____

Patient Signature: _____ Date:_____ Doctor Signature: _____

Have there been any changes to your health history since your last visit? ___ Yes ___ No

For what conditions? _____

Are you taking any new medications? ___ Yes ___ No If so, what? _____

Patient Signature: _____ Date:_____ Doctor Signature: _____

This Agreement can be signed online or digitally and shall be effective upon the date specified in the Agreement.

GEORGE HAROUNI DDS
General & Cosmetic Dentistry
www.georgeharounidds.com

Patient Name : _____

Patient Date of Birth:_____

HIPAA NOTICE OF PRIVACY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (all medical information including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

The Authorized Party (George Harouni DDS/Advantage Dental Care) has my authorization to disclose any information regarding my treatment to: **(check one)**

☐ Any party that is approved by the Authorized Party (George Harouni DDS/Advantage Dental Care).
☐ ONLY the following are allowed access to records (List someone other than yourself) :

Recipient Name: _____

_____

_____

I have also been informed of, and given the right to review and secure a copy of your *HIPAA Notice of* Privacy *Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient or Guardian Signature:_____ Date:_____

Guardian Print Name:_____

Relationship to Patient:_____

This Agreement can be signed online or digitally and shall be effective upon the date specified in the Agreement.

GEORGE HAROUNI DDS
General & Cosmetic Dentistry
www.georgeharounidds.com

NOTICE OF PRIVACY PRACTICES (PATIENT COPY)

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/13/2023 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, Text messages, Emails or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on a Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Advantage Dental Care
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