SMILE CENTER
CAMPBELLSVILLE

WELCOME

WE WOULD LIKE TO WELCOME YOU TO OUR OFFICE. IN AN EFFORT TO PROVIDE THE BEST SERVICE POSSIBLE, WE ASK YOU TO FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE. THANKS YOU FOR YOUR COOPERATION

PATIENT INFORMATION

NAME _____ (LAST / FIRST / MIDDLE) M / F (SEX) M / S / D (MARTIAL STATUS)

ADDRESS _____ (STREET / CITY / STATE / ZIP)

BIRTHDAY _____ EMAIL _____ SOCIAL SECURITY # # _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EXT.

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

GENERAL DENTIST _____ LAST VISITED _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

SPOUSE / ADDITIONAL CONTACT INFORMATION

NAME _____ (LAST / FIRST / MIDDLE) M / F (SEX) M / S / D (MARTIAL STATUS)

ADDRESS _____ (STREET / CITY / STATE / ZIP)

BIRTHDAY _____ EMAIL _____ SOCIAL SECURITY # # _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EXT.

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

INSURANCE INFORMATION

POLICY OWNER'S NAME _____ POLICY OWNER'S SOCIAL SECURITY # _____

POLICY OWNER'S BIRTHDAY _____ RELATIONSHIP TO PATIENT _____

POLICY OWNER'S EMPLOYER _____ POLICY HOLDER PHONE # _____

INSURANCE COMPANY _____ GROUP OR PLAN # _____

INSURANCE CO. ADDRESS _____ INSURANCE PHONE NO. _____

SECONDARY INSURANCE

POLICY OWNER'S NAME _____ POLICY OWNER'S SOCIAL SECURITY # _____

POLICY OWNER'S BIRTHDAY _____ RELATIONSHIP TO PATIENT _____

POLICY OWNER'S EMPLOYER _____ POLICY HOLDER PHONE # _____

INSURANCE COMPANY _____ GROUP OR PLAN # _____

INSURANCE CO. ADDRESS _____ INSURANCE PHONE NO. _____

SMILE CENTER
CAMPBELLSVILLE

PATIENT NAME: BIRTH DATE:

ALTHOUGH DENTAL PERSONNEL PRIMARLY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. PLEASE NOTE ANY HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION

ARE YOU UNDER A PHYSICAN'S CARE NOW?	☐ YES	☐ NO	IF YES, DR'S NAME:
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION?	☐ YES	☐ NO	
IF YES, LIST REASON:			
HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY?	☐ YES	☐ NO	IF YES:
ARE YOU TAKING ANY MEDICATION, PILLS, OR DRUGS INCLUDING NATURAL SUPPLEMENTS, VITAMINS, OR HERBS?	☐ YES	☐ NO	
IF YES, LIST:			
DO YOU TAKE, OR HAVE TAKEN, PHEN-FEN OR REDUX?	☐ YES	☐ NO	IF YES:
HAVE YOU EVEN TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES?	☐ YES	☐ NO	IF YES:
DO YOU USE TOBACCO?	☐ YES	☐ NO	
DO YOU HAVE ANXIETY RELATED TO THE DENTAL OFFICE OR DENTAL PROCEDURES?	☐ YES	☐ NO	IF YES:

WOMEN: ARE YOU...
☐ PREGNANT? ☐ TAKING ORAL CONTRACEPTIVES? ☐ TRYING TO GET PREGNANT? ☐ NURSING?

ARE YOU ALERGIC TO ANY OF THE FOLLOWING? ☐ NO KNOWN DRUG ALLERGIES

☐ ASPIRIN	☐ PENICILLIN	☐ CODEINE	☐ SULFA DRUGS
☐ ACRYLIC	☐ METAL	☐ LATEX	☐ LOCAL ANESTHETIC

OTHER ALLERGIES NOT LISTED?	☐ YES	☐ NO	IF YES:
DO YOU USE A CONTROLLED SUBSTANCES?	☐ YES	☐ NO	IF YES:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

☐ ADHD	☐ AIDS/HIV POSITIVE	☐ ALZHEIMER'S DISEASE	☐ ANAPHYLAXIS
☐ ANEMIA	☐ ANGINA	☐ ARTHRITIS/GOUT	☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL - JOINT	☐ ASPERGER'S SYNDROME	☐ ASTHMA	☐ AUTISM
☐ BLOOD DISEASE	☐ BLOOD TRANSFUSION	☐ BREATHING PROBLEMS	☐ BRUISE EASILY
☐ CANCER	☐ CHEMOTHERAPY	☐ CHEST PAINS	☐ COLD SORES/FEVER BLISTERS
☐ CONGENITAL HEART DISORDER	☐ CORTISONE MEDICINE	☐ DIABETES	☐ DRUG ADDICTION
☐ EASILY WINDED	☐ EMPHYSEMA	☐ EPILEPSY OR SEIZURES	☐ EXCESSIVE BLEEDING
☐ EXCESSIVE THIRST	☐ FAINTING/DIZZY SPELLS	☐ FREQUENT COUGH	☐ FREQUENT HEADACHES
☐ GLAUCOMA	☐ HEART ATTACK/FAILURE	☐ HEART MURMUR	☐ HEART PACEMAKER
☐ HEART TROUBLE / DISEASE	☐ HEMOPHILIA	☐ HEPATITIS A	☐ HEPATITIS B OR C
☐ HERPES	☐ HIGH BLOOD PRESSURE	☐ HIGH CHOLESTEROL	☐ HIVES OR RASH
☐ HYPOGLYEMIA	☐ IRREGULAR HEARTBEAT	☐ KIDNEY DIALYSIS	☐ LEUKEMIA
☐ LIVER DISEASE	☐ LOW BLOOD PRESSURE	☐ LUNG DISEASE	☐ MITRAL VALVE PROLAPSE
☐ MULTIPLE SCLEROSIS	☐ MUSCULAR DYSTROPHY	☐ OSTEOPOROSIS	☐ PAIN IN JAW JOINTS
☐ PARATHYROID DISEASE	☐ PSYCHIATRIC CARE	☐ RADIATION TREATMENTS	☐ RECENT WEIGHT LOSS
☐ RHEUMATIC FEVER	☐ SCARLET FEVER	☐ SHINGLES	☐ SICKLE CELL DISEASE
☐ SINUS TROUBLE	☐ SPINA BIFIDA	☐ STOMACH/INTESTINAL DISEASE	☐ STROKE
☐ SWELLING OF LIMBS	☐ THYROID DISEASE	☐ TONSILLITIS	☐ TUBERCULOSIS
☐ TUMORS OR GROWTHS	☐ ULCERS	☐ YELLOW JAUNDICE	☐ COPD

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED?	☐ YES	☐ NO	IF YES:
DO YOU HAVE ANY SPECIAL MEDICAL OR MENTAL NEEDS NOT LISTED?	☐ YES	☐ NO	
IF YES:			

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

_____

SMILE CENTER CAMPBELLSVILLE

1485 OLD LEBANON ROAD
CAMPBELLSVILLE, KY 42718
270-789-2155

FINANCIAL AGREEMENT:

AS OUR PATIENT, WE WANT TO PROVIDE YOU WITH THE BEST CARE POSSIBLE. THERE MAY BE CERTAIN ROUTINE SERVICES THAT WE FEEL ARE NECESSARY FOR THE MAINTENANCE OF GOOD ORAL HEALTH, WHICH ARE NOT COVERED BY INSURANCE. YOU WILL BE RESPONSIBLE TO PAY FOR ALL SERVICES NOT COVERED. CO-PAYMENTS ARE DUE AT TIME OF SERVICE. I HAVE READ THE FINANCIAL POLICY AND, BY MY SIGNATURE, AGREE TO PAY FOR SERVICES AS AGREED UPON FOR ALL PLANS OF TREATMENT.

ACKNOWLEDGEMENT OF RECEIPT:

I ACKNOWLEDGE THAT I HAVE RECEIVED AND/OR READ A COPY OF THE NOTICE OF PRIVACY PRACTICES.

ASSIGNMENT AND RELEASE:

I ASSIGN TO THE SMILE CENTER, PLLC, BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICE(S) RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTORS TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

THE SIGNATURE BELOW IS ACKNOWLEDGEMENT OF HIPPA CONSENT, NOTICE OF PRIVACY POLICIES, INSURANCE AUTHORIZATION AND RELEASE AND FINANCIAL POLICY OF THIS OFFICE.

PATIENT/GUARDIAN _____ DATE _____

SMILE CENTER CAMPBELLSVILLE
1485 OLD LEBANON ROAD
CAMPBELLSVILLE, KY 42718
270-789-2155

PREVIOUS DENTAL PRACTICE: _____

_____

_____

BY SIGNATURE BELOW, I AUTHORIZE THE TRANSFER OF MY DENTAL RECORDS AND X-RAYS FROM THE OFFICE INDICATED TO THE PRACTICE OF MARLENE K RICHARDSON, DMD, AND ABBY H COYLE, DMD.

PATIENT: _____

DOB: _____

SS: _____

PATIENT/GUARDIAN _____ DATE _____

Smile Center Campbellsville
1485 Old Lebanon Rd Campbellsville, KY 42718

NOTICE OF PRIVACY PRACTICES

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 April 1st, 2003, 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 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 healthcare 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 make revoke it in writing at any time. Your revocation will not affect any use or disclosure 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.

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 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 use or 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, or 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 and safety or the health and 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 authorized federal officials health information required by 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, texts, postcards, 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 provide the format you request unless we cannot practicably 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 may 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 for each page, per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12- month period, we may charge you for 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 satisfactory explanation 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

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 US Department of Health and Human Services.

Contact Officer: Debbie Meadows Telephone: 270-789-2155 • Address: 1485 Old Lebanon Road Campbellsville KY 42718

SMILE CENTER CAMPBELLSVILLE
1485 OLD LEBANON ROAD
CAMPBELLSVILLE, KY 42718
270-789-2155

FINANCIAL POLICY
Thank you for choosing Dr's Richardson and Coyle and allowing us to provide your dental healthcare needs. The policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients at an affordable cost.

RESPONSIBILITY FOR THE BILL
It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While this office will file verified insurance for payment of the bill(s) as a courtesy to our patients, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of this office at the present time.

BROKEN APPOINTMENT FEE
Effective September 1, 2011, a $25 Broken Appointment Fee will be charged for ANY change made to your appointment with less than 24 hours notice. This fee must be paid before another appointment can be scheduled.

POINT OF SERVICE COLLECTIONS
Payment for service is due at the time the service(s) is rendered. Payment will be accepted with cash, check, credit/debit card or Care Credit financing. We will be happy to file verified insurance on your behalf. A finance charge of 1.5% per month is assessed after thirty (30) days.
If your insurance requires a deductible or percentage, it will be due at the time of service.
Patients unable to comply with the Point-of-Service payment policy will be referred to the Credit Manager for necessary arrangements.

PAYMENT ARRANGEMENTS
After the initial visit for which payment is due in full at the time of service, this office will make a reasonable effort to assist patients in meeting their financial obligations. Care Credit offers both a short term (up to 18 months) interest free plan as well as an extended payment plan up to 60 months. The rate for the extended payment plan is subject to change. We also offer for those patients who prefer to make payment directly to this office, a half and half payment plan at 18% APR. This payment plan is offered to patients that will need two or more appointments with the first payment being due at the time of the visit and the remaining payment being due at the seat or final appointment. A Financing Agreement must be signed by the responsible party at the time of service. While this may not alter payments on existing balances from prior arrangements made, it takes effect as of the date of signature of this document on all new balances.

ACCEPTANCE OF INSURANCE
This office will accept "Assignment of Benefits" of verified insurance policies and submit a bill to the carrier on the patient's behalf. It is understood that insurance is filed as a courtesy and does not relieve the patient of financial responsibility. Deductibles and percentages are due at the time of service.

SECONDARY INSURERS
Having more than one insurer does not necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy. The patient/guarantor is responsible for any balances after all insurance(s) have cleared.

RELEASE OF INFORMATION
By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

PATIENT RESPONSIBILITY
Balance after insurance payment is due within 30 days of that insurance payment, unless other satisfactory arrangements have been made with this office. Balances not paid within 30 days are subject to a monthly finance charge of 1.5% of the current balance.

All services are not covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers that service or not.

This office cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

DIVORCE DECREES
This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

MINOR PATIENTS
The adult accompanying a minor on the visit will be responsible for payment.

BAD DEBT
If the account is not paid in full or satisfactory arrangements made within the allowable time frames, this office reserves the right to refer the account to our attorney for collection of the debt. It is agreed that Kentucky shall have jurisdiction over any dispute and that venue is proper in Taylor County, Kentucky.

The Administration and Management welcomes the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality dental care.