ROSEWOOD DENTAL
PATIENT INFORMATION

PERSONAL INFORMATION

Patient Name Last First Middle	Sex	Marital Status S M W D SEP	Date of Birth	SS#	Age
Patient Address	City	State	Zip	Phone ( )	
E-Mail Address	Cell Phone ( )		Whom may we thank for referring you?		
Employer	Position	Employer Address	Work Phone ( ) Ext		

RESPONSIBLE PARTY OR AUTHORIZED AGENT INFORMATION

Responsible Party (circle) Patient Father Mother Husband Wife Other	Name		Date of Birth
Address	City	State	Zip	Phone ( )
Employer	Occupation	SS#	
Employer's Address	City	State	Zip	Phone ( ) Ext

ADDITIONAL CONTACTS

Name of Relative (other than living with you)	Relationship	Address	Phone ( )
Friend	Address		Phone ( )

INSURANCE COMPANY (Primary)	**INSURANCE COMPANY (Secondary)**
Employer Name _____	Employer Name _____
Insurance Name _____	Insurance Name _____
Address _____	Address _____
Phone _____ ID # _____	Phone _____ ID# _____
POLICY HOLDER INFORMATION	**POLICY HOLDER INFORMATION**
Policy Holder_____	Policy Holder_____
Relation of Patient to Insured ___ Self __ Spouse___ Child __ Other	Relation of Patient to Insured ___ Self ___ Spouse ___ Child ___ Other
Date of Birth _____	Date of Birth_____
Street _____	Street_____
City/State/Zip _____	City/State/Zip _____
Phone ( ) _____	Phone ( ) _____
SS# _____ Group # _____	SS# _____ Group # _____

AGREEMENT OF EXTENSION OF CREDIT

"In accordance with the Federal Truth In Lending Act, please be advised of the following office policies in connection with the extension of credit. By signing this agreement, the patient, legal guardian, authorized agent or the responsible party agrees to:

1. Pay in full each time services are rendered, or by previous agreement. We accept cash, check, or most major credit cards.
2. Pay 1.75% per month (21% APR) on any unpaid balance over 30 days past due, with a $2.00 minimum.
3. Authorize a credit bureau report to be obtained when deemed necessary.
4. I grant my permission to you or your assignee to telephone me at my home or at my workplace to discuss matters related to my treatment or account.
5. Pay a $20.00 fee on all returned checks.
6. You authorize us to contact you by telephone at any telephone, including any cellular, mobile, & other wireless telephone numbers you have or may attain. You authorize us, and any other person or entity who provides goods or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded /artificial voice messages and/or the use of an automatic telephone dialing system, as applicable.

I agree to pay the remaining balance due plus a 40% collection agency fee on my delinquent account if placed with a collection agency. I also agree to pay any court costs and reasonable attorney fees if my account is placed with or without suit.

_____ _____ _____

Signature Date Print Name

MEDICAL HISTORY

PATIENT NAME:_____ DATE OF BIRTH:_____

PHYSICIAN'S NAME:_____ PHONE:_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

		YES	NO
1.	Do you consider yourself to be in good health?	☐	☐
2.	Are you now or have you been under a physician's care within the past year? If Yes, specify condition being treated_____	☐	☐
		YES	NO
3.	Do you take any medications, including birth control pills? Please specify name and purpose of medications:_____ _____	☐	☐
		YES	NO
4.	Do you have or have you ever had any heart or blood problems?	☐	☐
5.	Have you ever been told that you have a heart murmur?	☐	☐
6.	Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?	☐	☐
7.	Do you have or have you ever had high blood pressure?	☐	☐
8.	Do you bleed or bruise easily?	☐	☐
9.	Have you ever been diagnosed as being HIV positive or having AIDS?	☐	☐
10.	Have you ever had hepatitis or liver disease?	☐	☐
		YES	NO
11.	Have you ever had: rheumatic fever_____; asthma_____; any blood disorder_____; diabetes_____; rheumatism_____; arthritis_____; tuberculosis_____; venereal disease_____; heart attack_____; kidney disease_____; immune system disorders_____; heart disease or endocarditis_____ other disease_____:Specify_____	☐	☐
12.	Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetaminophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other	☐	☐
		YES	NO
13.	Are you subject to fainting?	☐	☐
14.	Have you ever had any severe reaction to dental treatment or local anesthetics?	☐	☐
15.	Are you allergic to any local anesthetic?	☐	☐
16.	Do you have any other allergies? If Yes, please describe:_____	☐	☐
		YES	NO
17.	Have you ever had a nervous breakdown or undergone psychiatric treatment?	☐	☐
18.	Have you ever received counseling for use of alcohol and/or prescription drugs?	☐	☐
19	Women: Are you pregnant?	☐	☐
20.	Are you now in pain?	☐	☐
21.	How long ago did you last see a dentist? _____		
22.	Who was your previous dentist?	YES	NO
23.	Do you think that your teeth are affecting your general health in any way?	☐	☐
24.	Do you have or have you ever had bleeding or sensitive gums?	☐	☐
	If Yes, have you seen your physician or cardiologist for a cardiac evaluation?	☐	☐
25.	Have you ever used or are you now using tobacco or alcohol?	☐	☐
26.	Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?	☐	☐

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ Date_____

(Patient, legal guardian or authorized agent of patient)

CONSENT TO PROCEED

PATIENT'S NAME_____.

I authorize Dr. Joseph Johnson / Landon Rockwell and /or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health of any minor or other individual for which I have responsibility, including arrangement and/ or any pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness. I do voluntarily assume any and all possible risk, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature:_____Date:_____.
(Patient, legal guardian or authorized agent of patient)

Witness:_____Date:_____.

ROSEWOOD DENTAL
Joseph C Johnson DDS
Landon B Rockwell DDS
181 West Vine Street
Tooele UT 84074
435-882-0099

Patient Name: _____

Insurance Co.
Primary: _____

Secondary: _____

THE FACTS ABOUT INSURANCE

Please understand we are desirous to extend care to you and to work with you and any insurance coverage you may have.

1. Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

2. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.

3. For your convenience we will ESTIMATE the portion of your total fee that your insurance company will cover. This is JUST AN ESTIMATE. After insurance benefits, you are responsible for ANY UNPAID BALANCE. We will ask you to bring with you at the time of treatment the ESTIMATED uncovered portion of the total fee.

4. If you desire to know exactly what your insurance coverage will be, prior to treatment, then we can pre-determine or pre-authorize your benefits. However, this delays treatment 4-6 weeks, waiting for the insurance company to respond.

5. A finance charge of 1 ½% per month will be added to your bill if payment has not been received with 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.

6. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I also authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. I hereby authorize release of information for insurance purposes.

Thank you for you understanding in this matter.

_____ _____
Patient or Responsible Party Date

Rosewood Dental Associates, LLC
181 West Vine Street
Tooele, Utah 84074
435-882-0099

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

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

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 09/22/2013, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

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

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI 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, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. 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 obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

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

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in

electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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 the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Mary Ann Hunt

Address: 181 West Vine Street Tooele, Utah 84074

Telephone: 435-882-0099

Fax: 435-882-1040

Email: marybhunt@yahoo.com

Rosewood Dental Associates, LLC

181 West Vine Street
Tooele, Utah 84074
435-882-0099

NOTICE OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES POLICY

EFFECTIVE: SEPTEMBER 22, 2013

BACKGROUND

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) gives individuals the right to be informed of their healthcare providers' privacy practices and the right to understand and control how their health information is used. Healthcare providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices.
Our Practice has made material changes to our privacy practices, consistent with legal changes to HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). We will be providing all of our patients with our revised and updated Notice of Privacy Practices, and requesting a signed acknowledgment of receipt from each patient.

SUMMARY OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES:

- We have added a statement to our Privacy Practices acknowledging that we may not use or disclose your protected health information for marketing purposes, including disclosures that constitute sales, without your authorization.
- We will be issuing new Patient Release of Records Authorization forms that allow patients to choose whether to allow or limit the Practice from disclosing their protected health information in certain ways, to include opting out of fundraising communications.
- If the Practice maintains a patient's psychotherapy notes, they will not be released unless you the patient signs an authorization or if otherwise required by law.
- Patients have the right to restrict the Practice from disclosing certain protected health information to health plan providers if the patient personally pays for their service in full.
- We have revised our internal privacy breach reporting practices to comply with 2013 changes in the HIPAA and HITECH privacy rules, and patients have a right to receive a notification of breaches of unsecured protected health information.
- Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose any genetic information to insurance providers or others for underwriting purposes.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Mary Ann Hunt

Address: 181 West Vine Street, Tooele, Utah 84074

Telephone: 435-882-0099

Fax: 435-882-1040

Email: marybhunt@yahoo.com

Rosewood Dental Associates, LLC

181 West Vine Street
Tooele, Utah 84074
435-882-0099

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Rosewood Dental Associate's Notice of Privacy Practices, which has an effective date of 09/22/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name

_____
Relationship to Patient (If not signed by the Patient)