East Louisville Dental Group

Dear _____:

You have an appointment with Dr. Anderson on _____,
_____, at _____.

Enclosed please find the paperwork requested to be completed and brought with you on the above date along with your insurance card. Also, please bring any x-rays or information that may be pertinent to your visit.

If you have any questions concerning your visit or need directions, please contact our office.

Thank you for your attention to this request.

Sincerely,

Office of
Sarah M. Anderson, D.M.D.

205 Moser Road
Louisville, Kentucky 40223
(502) 245-5418
fax (502) 245-5429

Dear New Patients,

One of the most important aspects of our attempt to provide you with the highest quality dental care available is your safety. We are committed to ensuring that all necessary precautions are taken to protect your health during your dental treatment.

All of our staff has had extensive training in infection control, and medical waste management procedures. We strictly adhere to the guidelines established by the American Dental Association, The Centers for Disease Control, and the Occupational Safety and Health Administration which include the use of "Universal Precautions".

Universal Precautions used in this office include:

A. Use of gloves, masks, and protective eyewear by all staff involved in direct patient care.
B. Hand washing with a germicidal surgical scrub before and after use of gloves. Gloves are changed each time a staff person exits or re-enters the treatment room.
C. Thorough wipe down of all hard surfaces (counter-tops) with a hospital grade disinfectant after each patient.
D. Use of disposable plastic covers on hard to clean surfaces. These plastic barriers are discarded after each patient.
E. Single patient use of nitrous oxide hoods.
F. Use of chemical disinfecting and ultrasonic cleaning baths for all hand instruments prior to sterilization.
G. Sterilization of all instruments, including handpieces (drills) using a steam autoclave.
H. Discarding of all paper, plastic, and rubber items after each patient.
I. Using a special puncture proof container for all used needles and sharp items. This is cataloged and sent to a hazardous waste disposal facility, where it is incinerated.
J. Disinfections of all laboratory models, impressions and prostheses (crown, dentures, etc.).
K. Weekly testing of steam autoclave via the University of Louisville's' sterilization monitoring service to ensure effectiveness.
L. Inoculation of staff members to protect them from Hepatitis B infection.
M. Obtaining and reviewing a thorough medical and dental history on each patient.

These procedures are very time consuming and costly, but necessary. It is for all of our safety that these procedures have been developed.

Thank you for allowing us to provide your dental care. If you have any questions, please do not hesitate to ask.

NEW PATIENT INFORMATION FORM

LASTNAME_____ TITLE____ FIRST NAME_____

MIDDLE NAME_____ PREFERED NAME_____ _____

HOME ADDRESS_____

HOME PHONE_____ WORK PHONE_____ SS#_____-_____-_____

DATE OF BIRTH____/____/_____ MARTIAL STATUS_____ SEX_____

REFERING DR._____ REFERING PATIENT_____

MEDICAL ALERTS_____

PRIMARY INSURANCE COVERAGE
SUBSCRIBER NAME AND ADDRESS_____
_____

RELATION TO PATIENT_____ SS#_____-_____-_____ DOB____/___/_____

EMPLOYER NAME & ADDRESS_____
_____

INSURANCE COMPANY NAME & ADRESS_____
_____

GROUP#_____ FAM YRLY DEDUCT_____ IND YRLY DEDUCT_____

SECONDARY INSURANCE COVERAGE
SUBSCRIBER NAME & ADDRESS_____
_____

RELATION TO PATIENT_____ SS#_____-_____-_____ DOB____/___/_____

EMPLOYER NAME & ADDRESS_____
_____

INSURANCE COMPANY NAME & ADDRESS_____
_____

GROUP#_____ FAM YRLY DEDUCT_____ IND YRLY DEDUCT_____

INSURANCE. Claims for dental insurance will be filled at time of treatment and the estimated portion of the charge due from the insurance will be considered current for a period of 45 days. If after 45 days the insurance has not paid, that portion will revert to the patients due balance for account aging purposes. Ultimately all charges are the responsibility of the patient/guarantor.

FINANCE CHARGE. If I do not pay the entire new balance within 30 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $134) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

RESPONSIBLE PARTY FOR PATIENT:
NAME & ADDRESS_____

SIGNATURE_____

GENERAL CONSENT FOR DENTAL TREATMENT

We are required to obtain your consent for the proposed dental treatment or oral surgery. Please read this form carefully, and we encourage you to ask us anything that you do not understand. We will be glad to explain it to you.

I hereby authorize and direct East Louisville Dental Group and its staff to perform upon me or my child, _____, the following dental treatment or oral surgical procedures including the necessary or advisable local anesthesia, radiographs, or diagnostic aids.

In general terms, the dental procedures may include one or a number of the following:

- Cleaning of teeth and application of topical fluoride
- Treatment of periodontal disease with deep cleaning, gum surgery, and bone/soft tissue grafting
- Application of sealants to the grooves of teeth
- Treatment of diseased or injured teeth with dental restorations, either amalgam (silver) or composite(white)
- The replacement of missing teeth with a dental prosthesis (crowns, bridges, partial/complete dentures etc.)
- Extraction (removal) of one or more teeth that cannot be saved
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of overlapped teeth and/or developmental abnormalities
- The use of sedative medications and/or nitrous oxide to control apprehension and anxiety

I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed. Alternative methods of treatment, if any, along with their advantages and disadvantages have been explained to me. I am advised that good results are expected; however, the possibility of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I fully understand and authorize the doctor to perform any necessary treatment that in his/her judgment will be in the best interest of my or my child's health, once treatment has begun.

Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgical procedures, medication, and/or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, and scarring. I understand and accept that complications may require medical assistance and hospitalization.

I also understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the gums or teeth that were not discovered during examination. The most common being the need for root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

I certify that I have read and fully understand this consent. I have been given the opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time I choose to terminate. Such termination of consent must be in writing.

Date: _____ Patient/ Parent/ Guardian Signature: _____

Witness: _____

Prior Dentist Name: _____

Address: _____

_____

Telephone Number: _____

I,_____, give permission of the release of my dental records and radiographs. Please mail them to:

Sarah M. Anderson, D.M.D.
P.O. Box 43300
Louisville, KY 40223

Thank you for your cooperation.

Sincerely,

East Louisville Dental Group

Sarah M. Anderson, DMD, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

East Louisville Dental Group

Sarah M. Anderson, DMD

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 (04/13/03), 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 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.

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 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 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 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 authorized 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, 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 use 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 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 will charge you $0.___ 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 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.

Electronic Notice: If you receive this Notice on our 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.

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 will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Contact Officer: Office Manager

Telephone: 502-245-5418

Fax: 502-245-5429

E-mail: info@eastlouisvilledentalgroup.com

Address: 205 Moser Road

Louisville, KY 40223