Southern Roots Periodontics

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Welcome to Southern Roots Perio: Implant & Laser Dentistry

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your child's health, please tell us. If you have any questions, please don't hesitate to ask.

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Parent/Guardian Information

The following is for:* ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ **SS#:** _____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Medical Insurance

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insurance ID: _____

Group ID: _____

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Health History

Patient Name and DOB: *

_____

_____

Please list all drugs your child is currently taking _____

Does your child have any congenital conditions? _____

Did your child receive the Vitamin K shot as a newborn? ◯ Yes ◯ No

May we send the information from today's visit to your child's physician? ◯ Yes ◯ No

Was your child premature? ◯ Yes ◯ No

Does your child have any heart disease? ◯ Yes ◯ No

Does your child or anyone in your immediate family have a history of a bleeding disorder? ◯ Yes ◯ No

Mother's Symptoms

Please check all that apply:

- ☐ Blanched
- ☐ Bleeding
- ☐ Blistered
- ☐ Bruised
- ☐ Continued Pain During Nursing
- ☐ Cracked
- ☐ Creased or Flattened Nipples
- ☐ Feelings of Depression
- ☐ Gumming or Chewing on Nipple
- ☐ Incomplete Breast Drainage
- ☐ Mastitis
- ☐ Nipple Trauma
- ☐ Oversupply of Breast Milk
- ☐ Recurring Plugged Ducts
- ☐ Severe Pain with Latch-On
- ☐ Sore
- ☐ Thrush Infected Nipples
- ☐ Undersupply of Breast Milk
- ☐ Using A Nipple Shield
- ☐ Using A SNS To Feed Child

Baby Symptoms

Please check all that apply: *

- ☐ Bad Breath
- ☐ Behavioral Issues
- ☐ Biting/ Clenching
- ☐ Breathing Pauses During Sleep
- ☐ Cheek Biting
- ☐ Chewing on Objects
- ☐ Choking/Coughing
- ☐ Clicking Sounds
- ☐ Colic Symptoms
- ☐ Daytime Sleepiness
- ☐ Dribbling
- ☐ Failure to Thrive
- ☐ Falling Asleep at Breast
- ☐ Feeding Issues with Bottle/Breast
- ☐ Frustration When Feeding
- ☐ Gagging
- ☐ Gas
- ☐ Grinds Teeth
- ☐ Inability to Latch
- ☐ Leaking
- ☐ Lip Sucking
- ☐ Mouth Breathing
- ☐ Nail Biting
- ☐ No Effective Latch On
- ☐ Poor Attention Span
- ☐ Poor Weight Gain
- ☐ Prolonged Feeding Times
- ☐ Reflux
- ☐ Refuses
- ☐ Sippy Cup Usage
- ☐ Slides Off Nipple
- ☐ Snoring
- ☐ Supplements with Bottle
- ☐ Thrush
- ☐ Thumb / Finger Sucking / Pacifier
- ☐ Tongue Thrust
- ☐ Unable to Hold Pacifier
- ☐ Unsatisfied Hunger After Feeding
- ☐ Unsustained Latch
- ☐ Upper Lip Blisters
- ☐ Upper Lip Curls in When Feeds
- ☐ Uses a Bottle

If any of the checked boxes need further explanation, please describe:

_____

_____

Release of Information

List individuals whom you would like involved in your childs care. By writing their names on this form, you consent to the release of your information to them (ex: spouse, children, etc.) This includes discussions on all related treatment, insurance payments and patient payments. In addition, the account holder (not necessarily insurance holder) may receive basic treatment information on mailed billing statements. Please provide provider name and telephone number, if available.

Patient Name _____

Name of Person Giving Consent _____

Pediatrician _____

Dentist _____

Lactation Consultant _____

Chiropractor/ CST/ OT/ PT _____

Speech Therapist _____

Other _____

Notice of Privacy Practices

Southern Roots Periodontics

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.

Uses and disclosures to carry out treatment, payment, and health care operations

Treatment- This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- This practice may use or disclose your protected health information
for billing, claims management, collection activities, or obtaining payment.

Health care Operation- This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

This practice may use or disclose protected health information to remind you of your appointment, to give you information about treatment alternatives, or other health related benefits or services. If you do not wish to receive appointment reminders or the information about treatment alternatives, other health related benefits, services, you may notify our office and you will receive no further information.

This practice may contact you for our **own** fundraising activities**.** If you do not want to receive fundraising communication, you may opt-out at any time. Each communication will contain methods to be used to opt-out of further communication. If you opt-out, you will receive no further fundraising communications. If at any time you wish to receive fundraising communication you wish to receive the communication again, you can contact our practice.

Authorized Uses or Disclosures

The following uses or disclosures require a **valid** authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- This practice will require an authorization for most uses and disclosures of psychotherapy notes, where applicable.

Uses or Disclosures for Market Purposes- This practice will require an authorization for uses and disclosures of protected health information used in marketing.

Disclosures for a Sale of Protected Health Information- This practice will require an authorization for any disclosures that would constitute a sale of protected health information**.**

For any other use or disclosure, you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law-This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities-This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence
This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities-This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings- This practice may,
in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes- This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents- This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes- This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes- This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety- This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures for specialized government-This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation-This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA

The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, **except as in the Right of Restriction section.**

Right of an individual to request a restriction of uses and disclosures
This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service. We will agree to this restriction as long as your payment is honored. If payment is not honored, we are not obligated to continue to abide by the requested restriction.

Confidential communication requirements
This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information
An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost-based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

Amendment of protected health information
An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information
An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12-month period. There will a reasonable cost-based fee for additional requests.

Right of Breach Notification
An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

Copy of this notice
You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties

This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices with be available and posted at our office(s) and posted on our web site, if applicable.

Complaints

If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice is October 7, 2019

PLEASE RETAIN THIS SHEET FOR YOUR RECORDS

Southern Roots Periodontics: Implant and Laser Dentistry

Insurance Authorization

Patients with dental and/or medical insurance understand that all medical & dental services are charged directly to the patient and that he or she is personally responsible for payment of all services. Southern Roots Periodontics will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account, if applicable. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We are not in network with any insurance company and will file all claims as out of network.

I authorize all of my insurance companies to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that currently, Southern Roots Periodontics is not in network with any insurances. For your convenience, we will file a claim if provided with your insurance information.

Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon imbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made prior. A service charge of $50 for any unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. A fee of $25.00 is charged for patients who miss or cancels more than one appointment without a 24-business hour notice, a $250.00 fee for all missed surgery appointments, a $35.00 fee for all returned checks, $50.00 fee will apply if we must consult a third party concerning your account, you will be responsible for all related charges/fees during the collection process.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information to the secured web site for the dental practice. I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded on my behalf. I understand the dental practice cannot and does not assume any responsibility for my use or misuse of patient information or other information transmitted, monitored, stored, uploaded or received using the site or the services.

By signing below, I acknowledge that I have read, understand, and will abide by the above-named policies and procedures.

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Date

_____ _____

Authorized Representative if not patient Relationship

Southern Roots Periodontics:
Implant & Laser Dentistry, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____ _____
Patient's Name / Personal Representative (as defined by HIPAA) Date

_____
Relationship to Patient

_____ _____
Signature Date

OFFICE USE ONLY:

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient, but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____

_____ _____
Employee Name Date

_____
Employee Signature

2120 N. BELTLINE BLVD. COLUMBIA, S. C. 29204 TELEPHONE (803) 782-0528 FAX (803) 782-1036

EMAIL: INFO@SOUTHERNROOTSPERIO.COM