RILEY DENTAL
ASSOCIATES OF CENTRAL VIRGINIA

1 PATIENT INFORMATION

Date _____

Whom may we thank for referring you? _____

****

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Birth Date _____

SS # _____

Sex: □ Male □ Female Age _____

□ Married □ Widowed □Single

□Minor □Separated □Divorced

****

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

****

Spouse/Parent Name _____

Birth Date _____ SS# _____

2 DENTAL INSURANCE

Primary Dental Insurance Co. _____

Subscriber's Name _____

Subscriber's Employer _____

Group # _____

Birth Date _____SS# _____

Relationship to Patient _____

****

Secondary Dental Insurance Co. _____

Subscriber's Name _____

Subscriber's Employer _____

Group # _____

Birth Date _____ SS# _____

Relationship to Patient _____

****

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company (ies)
Riley Dental Associates of Central Virginia all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dental group may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (____)_____

Work (____)_____ Ext _____

Cell (____)_____

Spouse's Work (____)_____

Best time and place to reach you _____

****

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household.)

Name _____

Relationship_____

Home (____)_____

4 FINANCIAL RESPONSIBLITY

Any unpaid balance after 60 days will incur a service charge that will be added to the account. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $500.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection of this account or future outstanding accounts. Returned checks are subject to a $40 fee and may be represented to your bank for payment.

_____
Patient Signature

_____
Date

5 DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

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

Bad breath	□Yes □No	Fingernail biting	□Yes □No	Orthodontic treatment	□Yes □No
Bleeding gums	□Yes □No	Food collection between teeth	□Yes □No	Pain around ear	□Yes □No
Blisters on lips or mouth	□Yes □No	Grinding teeth	□Yes □No	Periodontal treatment	□Yes □No
Burning sensation on tongue	□Yes □No	Gums swollen or tender	□Yes □No	Sensitivity to cold	□Yes □No
Chew on one side of mouth	□Yes □No	Jaw pain or tiredness	□Yes □No	Sensitivity to heat	□Yes □No
Cigarette, pipe, or cigar smoking	□Yes □No	Loose teeth or broken fillings	□ Yes □No	Sensitivity to sweets	□Yes □No
Clicking or popping jaw	□Yes □No	Mouth breathing	□Yes □No	Sensitivity when biting	□Yes □No
Dry mouth	□Yes □No	Mouth pain with brushing	□Yes □No	Sores or growths in mouth	□Yes □No

How often do you brush _____ How often do you floss _____

6 HEALTH HISTORY

Family Physician's Name _____ Date of last visit _____

Has any doctor told you that you need to take an antibiotic before dental procedures due to a medical condition? Please circle Yes No

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

AIDS/HIV	□Yes □No	Epilepsy	□Yes □No	Rheumatic Fever	□Yes □No
Anemia	□Yes □No	Fainting or dizziness	□Yes □No	Scarlet Fever	□Yes □No
Arthritis, Rheumatism	□Yes □No	Glaucoma	□Yes □No	Shortness of Breath	□Yes □No
Artificial Heart Valves	□Yes □No	Headaches (Chronic)	□Yes □No	Sinus Trouble	□Yes □No
Artificial Joints	□Yes □No	Heart Murmur	□Yes □No	Stroke	□Yes □No
Asthma	□Yes □No	Heart Problems	□Yes □No	Swollen Feet or Ankles	□Yes □No
Autism/Developmental Delay	□Yes □No	Hepatitis Type	□Yes □No	Swollen Neck Glands	□Yes □No
Back Problems	□Yes □No	Herpes	□Yes □No	Thyroid Problems	□Yes □No
Bleeding abnormally, with extractions or surgery	□Yes □No	High Blood Pressure	□Yes □No	Tonsillitis	□Yes □No
		Jaundice	□Yes □No	Tuberculosis	□Yes □No
Blood Disease	□Yes □No	Kidney Disease	□Yes □No	Tumor or growth on head or neck	□Yes □No
Cancer	□Yes □No	Liver Disease	□Yes □No		
Chemical Dependency	□Yes □No	Low Blood Pressure	□Yes □No	Ulcer	□Yes □No
Chemotherapy	□Yes □No	Mitral Valve Prolapse	□Yes □No	Weight Loss, unexplained	□Yes □No
Circulatory Problems	□Yes □No	Nervous Problems	□Yes □No		
Cortisone Treatments	□Yes □No	Pacemaker	□Yes □No		
Cough, persistent or bloody	□Yes □No	Psychiatric Care	□Yes □No		
Diabetes	□Yes □No	Radiation	□Yes □No		
Emphysema	□Yes □No	Respiratory Disease	□Yes □No		

****

Women:

Are you pregnant? □Yes □No Due Date _____ Are you nursing? □Yes □No

Taking birth control pills? □Yes □No

MEDICATIONS	ALLERGIES
List any medications you are currently taking and the correlating diagnosis: _____	□Aspirin □Latex
_____	□Barbiturates (Sleeping pills) □Local Anesthetic
_____	□Codeine □Penicillin
Pharmacy Name _____	□Iodine □Sulfa
Phone ( )	□Other _____ □mycins

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/13/2014, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

> Prevent or control disease, injury or disability; report child abuse or neglect; report reactions to medications or problems with products or devices; notify a person of a recall, repair, or replacement of products or devices; notify a person who may have been exposed to a disease or condition; or notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Dana S. Fitch Telephone: 434-385-7707 Fax: 434-385-0738
Address: 3709 Old Forest Road Lynchburg, VA 24501 E-mail: dana@rileydentalassociates.com

RILEY DENTAL
ASSOCIATES OF CENTRAL VIRGINIA

Acknowledgement of Receipt of Notice of Privacy Practices

This form illustrates how Riley Dental Associates obtains acknowledgement of receipt of its Notice of Privacy Practices or documents its good faith effort to obtain that acknowledgement.

* You May Refuse to Sign This Acknowledgment*

I have reviewed a copy of this office's Notice of Privacy Practices. I may receive a paper copy of the Notice of Privacy practices upon my request.

Print Name:_____ Signature:_____

Date:_____

I give consent to the following people to discuss my appointments, account balance, and prescription/medical information.

_____

_____

_____

******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(PleaseSpecify)

  _____

  _____

RILEY DENTAL
ASSOCIATES OF CENTRAL VIRGINIA

ABOUT OUR PRACTICE

Office Hours:

Monday – Thursday: 8:00 am – 5:00 pm
Friday: 7:00 am – 3:00 pm

Appointments

We see all patients on a scheduled appointment basis and we have reserved that time specifically for you. Our goal is to see each patient at their scheduled time; however, sometimes emergencies or difficulties with a prior patient may arise. If this occurs, our front staff will keep you informed of any delays.

Cancellations

We understand that circumstances may require you to change your appointment. **If you are unable to keep your appointment, we do ask that you contact us 24 hours prior to the appointment time so that we may use this time for other patients who are waiting for dental services**. Because we send text/email messages and call to confirm all appointments, a fee will be charged for insufficient notice of cancelled or missed appointments.

Emergencies

If you have a dental emergency, please contact our office immediately. If during office hours, we will work out a time for you to be seen based on symptoms and need. If after hours, call the office for instructions on how to reach the dentist on call. If you reach an answering machine, please leave a detailed message and the dentist will return your call in a timely fashion.

Please note that we cannot prescribe pain medication after hours or if we have not seen you for the condition causing the pain. You must contact us during office hours for any prescriptions. For refills, please contact your pharmacy.

Recall Visits

The key to good oral health is regular preventive care visits. Typically, patients should be seen every 3-6 months for a cleaning and an examination depending on individual needs. Bitewing x-rays are generally taken once per year. For your convenience, we will schedule your next cleaning while you are in the office. We will send reminder messages, either notifying you that your appointment is approaching or that you need to make an appointment. We will send text/email messages to confirm your scheduled appointment as well. Please make sure we have your correct address and telephone numbers on file.

Insurance and Payment Options

As a courtesy to our patients, we will file all insurance claims free of charge. Our office is committed to helping you maximize your insurance benefits. You are responsible for any charges regardless of whether or not you have dental insurance; however, we will estimate what we anticipate your insurance will pay and collect the balance due at the time of service. Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated portion will be due at the time of service. You will be responsible for any unpaid insurance balance if insurance does not pay their entire estimated portion. If you have any questions, our courteous staff is always available to assist you.

Forms of payment accepted by our office are cash, check, VISA, MasterCard, Discover, American Express, and Care Credit. Our office offers deferred interest/no interest if paid in full by the end of the promotional period financing though Care Credit.

For all dental needs, a complete treatment plan will be outlined for you. If you have insurance and major dental needs, as a courtesy to you, your treatment plan will be submitted for a pre-estimate of coverage.

Infection Control

Our office houses the most state-of-the-art infection control centers available which complies with the Occupational Safety and Health Administration (OSHA) and Center for Disease Control (CDC) standards. For your protection, we use steam and dry heat sterilization of our instruments and hand pieces. Instruments are cleaned, wrapped and sterilized and kept intact until opened chairside during your appointment. We also use disposable products whenever possible.

Contact Our Office

Riley Dental Associates of Central Virginia, Inc.
3709 Old Forest Road
Lynchburg, Virginia 24501
Phone: 434-385-7707
Fax: 434-385-0738
www.rileydentalassociates.com
info@rileydentalassociates.com