CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutally agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. **Our office does not guarantee that your insurance will pay.** We make every attempt, at the beginning of your care to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. Any balance due, after your insurance will be billed promptly. Our software is designed for family accounts. If you do not want all family members on the same account it is the patient's responsibility to inform us at the initial appointment. **Please note we will only send a statement when a patient balance is due. A service fee of $8.00 will be added each month to your account for any additional statements mailed. Please note that any unpaid accounts will be forwarded to an outside agency for collection and any additional cost/fees incurred during the collection process with be the responsibility of the patient.** A fee of 30% will be added to the account balance at the time the account is forwarded to collection. If the percentage is under $35.00 a fee of $35.00 is automatically added before the account is forwarded.

I understand and agree the policies stated above:

_____

Signature of Patient or Guardian Date

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE?_____

NAME:_____ RELATIONSHIP:_____

PERSON TO CONTACT FOR EMERGENCY:

NAME:_____ CELL/HM #:_____

YOU WERE REFERRED TO US BY:_____

540 Willowbrook Road, Columbus, MS 39705 Tele:662-327-4523

Mark A. Nobles, DMD **Willowbrook Dental Center** Ben W. Harrelson, DMD

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

DATE:_____

LAST NAME:_____ FIRST:_____ M.I.:_____

ADDRESS:_____ CITY:_____ STATE/ZIP:_____

HOME:_____ CELL:_____ WK:_____

BIRTHDATE:_____ AGE:_____ MALE/ FEMALE MARRIED /SINGLE / DIVORCED /WIDOWED

SOCIAL SECURITY NO._____ EMPLOYER:_____

POSITION : _____ EMAIL ADDRESS:_____

SPOUSE:_____ SPOUSE CELL# _____

IF PATIENT IS A CHILD OR DEPENDANT:

MOTHER'S NAME:_____ DOB:_____ SOCIAL SECURITY NO._____

ADDRESS:_____ CITY:_____ STATE/ZIP:_____

EMPLOYER:_____ WK:_____ HOME:_____ CELL:_____

FATHER'S NAME:_____ DOB:_____ SOCIAL SECURYTY NO:_____

ADDRESS:_____ CITY:_____ STATE/ZIP:_____

EMPLOYER:_____ WK:_____ HOME:_____ CELL:_____

** Please note the parent that brings the child/dependant to the appointment and signs this form is the responsible party.*****

DENTAL INSURANCE :

PRIMARY CARRIER:

INSURANCE:_____ GROUP:_____

EMPLOYER NAME:_____ WORK NUMBER:_____

INSURED'S NAME:_____ DATE OF BIRTH:_____

INSURED I/D #:_____ SOCIAL #:_____

SECONDARY CARRIER:

INSURANCE:_____ GROUP:_____

EMPLOYER NAME:_____ WORK NUMBER:_____

INSURED'S NAME:_____ DATE OF BIRTH:_____

INSURED I/D #:_____ SOCIAL #:_____

✳ Have you ever had a joint replacement? Example: Knee, hip, shoulder: Yes / No

If **Yes,** most patients were given a prescription for an antibiotic to take prior to their dental appointments.

If you recently had a procedure and are unsure if you should pre medicate with an antibiotic please contact the provider who preformed the surgery. Have your prescription filled and bring the bottle with you to your appointment. We will note the prescription in your chart for future appointments.

Name of provider and type of surgery:_____

Please provide a complete list of medications along with the dosage you currently take.

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

13._____

14._____

15._____

✳ **Have you ever taken an injectable medication for weight loss?**_____

Name of medication:_____

Medical History

1. Physicians's name _____ Phone ( ) _____
   Have you had and medical care within the past two years?..... Yes No
   Describe_____
2. Have you taken any medication or drugs during the past two years?..... Yes No
   If yes, please list name and dosage Please list all medications and dosage on the next sheet
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosage of asprin?..... Yes No
   If yes, please list name and dosage Please list all medications and dosage on the next sheet
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other disphosphonates?..... Yes No
   If yes, please list name and dosage_____
5. Are you aware of having an allergic (or adverse) reaction to any substance or medication?..... Yes No
   If yes, please specify _____
6. Have you been patient in the hospital during the past five years?..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)... Yes No	Ulcers..... Yes No	Hepatitis A B C (circle) ..... Yes No
Chest Pain..... Yes No	Diabetes..... Yes No	Venereal Disease..... Yes No
Congenital Heart Disease..... Yes No	Thyroid Problems..... Yes No	A.I.D.S./H.I.V. Positive..... Yes No
Heart Murmur..... Yes No	Glaucoma..... Yes No	Cold Sores/Fever Blisters..... Yes No
High/Low Blood Pressure..... Yes No	Contact lenses..... Yes No	Blood Transfusion..... Yes No
Mitral Valve Prolapse..... Yes No	Emphysema..... Yes No	Hemophilia..... Yes No
Artificial Heart Valve/Pacemaker.... Yes No	Chronis Cough..... Yes No	Sickle Cell Disease..... Yes No
Rheumatic Fever..... Yes No	Tuberculosis..... Yes No	Bruise Easily..... Yes No
Arthritis/Rheumatism..... Yes No	Asthma..... Yes No	Liver Disease/Yellow Jaundice..... Yes No
Cortisone Medicine..... Yes No	Hay Fever/Allergy/Hives..... Yes No	Neurological Disorders..... Yes No
Swollen Ankles..... Yes No	Latex Sensitivity..... Yes No	Epilepsy or Seizures..... Yes No
Stroke..... Yes No	Sinus Trouble..... Yes No	Fainting or Dizzy Spells..... Yes No
Diet (Special/Restricted)..... Yes No	Radiation Therapy..... Yes No	Nervous/Anxious..... Yes No
Artificial Joints (hip, knee, etc.)..... Yes No	Chemotherapy..... Yes No	Psychiatric/Psychological care..... Yes No
Kidney Trouble..... Yes No	Tumors..... Yes No	Cancer..... Yes No

8. Have you lost or gained more than 10 pounds in the past year?..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed?..... Yes No
   If yes, please list:_____
10. **Women:** Are you pregnant or think you could be pregnant? Yes ____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions?..... Yes No

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature_____ Date_____

Please List all medications and dosage on the next sheet. Thank you

DENTAL HISTORY

What is the reason for your visit today? _____

_____

How often do you have dental examinations?_____

How often do you brush your teeth_____ How often do you floss_____

Have you ever used or are currently using topical floride? YES NO

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? YES NO if yes, please describe _____

_____

Are any of your teeth sensitive to:

Hot cold?..... Yes No

Sweets?..... Yes No

Biting or Chewing?..... Yes No

Have you noticed any mouth odors or bad tastes..... Yes No

Do you frequently get cold sores, blisters or any other oral lesions..... Yes No

Do your gums bleed or hurt?..... Yes No

Have your parents experienced gum disease or tooth loss?..... Yes No

Have you noticed any loose teeth or change in your bite?..... Yes No

Does food tend to become caught in between your teeth?..... Yes No

If yes, where_____

Do you:

Clench or grind your teeth while awake or asleep?..... Yes No

Bite your lips or cheeks regularly?..... Yes No

Hold foreign objects with your teeth?..... Yes No

Mouth breathe while awake or asleep?..... Yes No

Have tired jaws, especially in the morning?..... Yes No

Snore or have any other sleeping disorders?..... Yes No

Smoke/chew tobacco or use other tobacco products?..... Yes No

Have you ever had:

Orthodontic Treatment?..... Yes No

Oral Surgery?..... Yes No

Periodontal Treatment?..... Yes No

Your teeth ground or the bite adjusted?..... Yes No

A bite plate or mouth guard?..... Yes No

A serious injury to the mouth or head?..... Yes No

Please describe, including cause_____

Have you experienced:

Clicking or popping of the jaw?..... Yes No

Pain?(joint, ear, side of face)..... Yes No

Difficulty in opening or closing the mouth?..... Yes No

Difficulty in chewing on either side of the mouth?..... Yes No

Headaches, neckaches or shoulder aches?..... Yes No

Sore muscles (neck, shoulders)?..... Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to replace your silver fillings?..... Yes No

Would you like to keep all of your teeth all of your life?..... Yes No

Do you feel nervous about having dental treatment?..... Yes No

Please describe_____

Have you ever had an upsetting dental experience?..... Yes No

Please describe_____

Have you ever been told to take a pre-medication prior to dental treatment?..... Yes No

Is there anything else about having dental treatment that you would like us to know?..... Yes No

If yes, please describe_____

_____

Insurance Assignment Policy

All insurance companies recite a disclaimer upon verification of coverage... which states they will provide the information regarding coverage under your policy, but anything quoted is not a guarantee of payment. That can only be determined upon receipt of your claim.

Claims are billed from this office daily for the service provided. Insurance claims processing can take anywhere from 2 weeks to 5 weeks. This includes pre treatment request. The Mississippi quality insurance law states clean claims must be paid within 45 days. If we do not receive payment within that period of time, a tracer will be sent. If the insurance does not pay within 90 days then you will be responsible for the claim amount.

Patient cost share, deductible, percentages are based on the information received at the time of insurance verifications. Amounts collected from you are based on the information provided by your insurance company. These are estimates only, not an exact amount. Your insurance can not provide us with an exact guarantee of their payment and therefore we can only offer an estimate of your responsibility. This means that you may receive a statement after your insurance has processed your claim.

The patient is responsible to inform the office of any changes in their dental insurance prior to their dental treatment. This information should be presented at the time of check in.

_____ _____

Signature of Patient/Gaurdian Date

****

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign the Acknowledgement

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

_____

Please Print Name

_____ _____

Signature Date

Communications Regarding My Accounts & Appointments

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts and appointments from any servicers and collections of my accounts, through various means such as 1.) any cell, landline, or text number that I provide. 2.) any email address that I provide. 3.) auto dialer systems. 4) voicemail messages and other forms of communications.

_____ _____

Responsible Party Signature **Date**

Willowbrook Dental Center, 540 Willowbrook Road, Columbus, MS 39705

Willowbrook Dental Center

ACKNOWLEDGEMENT & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name:_____ **DOB:**_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You must read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reservice the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Juie Howell, Administrator
Telephone: 662-327-4523
E-Mail: Willowbrookdentalcenter@gmail.com
Address: 540 Willowbrook Rd, Columbus, MS 39705

Right to Revoke: Your will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____ Relationship:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Personal Representatives – We may only disclose your PHI to a personal representative authorized by you in writing.

Business Associates – We may share your PHI with business associates who perform services on our behalf. These business associates are required by law to safeguard your information.

Workers' Compensation – We may disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS

Some health information is considered especially sensitive and receives enhanced protection under federal law, including information related to Substance Use Disorder (SUD).

Even if this practice is not a substance use treatment provider, these protections may apply if we receive, maintain, or transmit SUD-related information as part of your health record.

How SUD Information May Be Used

SUD-related records may be used and disclosed for treatment, payment, and healthcare operations, as permitted by law, unless you request additional restrictions.

Prohibition on Legal Use

SUD-related records may not be used against you in criminal, civil, or administrative proceedings without your written consent or a specific court order.

Redisclosure Limitations

SUD-related information may not be redisclosed unless permitted by law. Additional restrictions may apply beyond standard HIPAA rules.

Fundraising Restrictions

Your SUD-related information will not be used for fundraising purposes without your consent. You have the right to opt out of fundraising communications.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- **Access** – Obtain a copy of your PHI
- **Amendment** – Request corrections to your PHI
- **Accounting of Disclosures** – Receive a list of certain disclosures of your PHI
- **Restrictions** – Request limitations on how we use or disclose your PHI
- **Confidential Communications** – Request communications in a specific manner/location
- **Fundraising Opt-Out** – Opt out of fundraising communications
- **Breach Notification** – Be notified of breaches of unsecured PHI
- **Complaints** – File a complaint with the Office for Civil Rights without retaliation

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. Any changes will apply to all PHI we maintain. The updated Notice will be available upon request, in our office, and on our website.

Dr. Mark A. Nobles, DMD

Willowbrook DENTAL CENTER

Dr. Ben W. Harrelson, DMD

NOTICE OF PRIVACY PRACTICES – HIPAA & 42 CFR PART 2

This Notice of Privacy Practices ("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.

Protected health information (PHI) includes information that identifies you and relates to your past, present, or future physical or mental health or condition, the healthcare services you receive, or payment for those services.

Some types of health information, including records related to Substance Use Disorder (SUD), receive additional protections under federal law, including regulations found at 42 CFR Part 2, in addition to HIPAA. These enhanced protections are explained later in this Notice.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that your health information is personal and confidential. We are committed to protecting the privacy and security of your protected health information (PHI). We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice
- Notify you if a breach occurs that may have compromised the privacy or security of your information

HOW WE MAY USE AND DISCLOSE YOUR PHI

Treatment – We may use and disclose your PHI to provide, coordinate, or manage your dental care and related services.

Payment – We may use and disclose your PHI to obtain payment for services provided to you.

Healthcare Operations – We may use and disclose your PHI for practice operations, including quality assessment, staff training, legal compliance, auditing, and business planning.

Appointment Reminders – We may use or disclose your PHI to contact you about appointments, reminders, or treatment alternatives.

Required by Law – We may use or disclose your PHI when required by federal, state, or local law.

Emergencies – We may use or disclose your PHI in emergency situations as necessary to protect your health or safety.

Public Health Activities – We may disclose PHI for public health purposes, including disease prevention and reporting.

Military, National Security, and Protective Services – We may disclose PHI as required for military activities, national security, and protective services.

Research – We may use or disclose your PHI for research purposes when approved by law and with appropriate safeguards.

Legal Proceedings – We may only disclose PHI in response to a valid court order or other lawful process or by your written consent.

Marketing – We will not use your PHI for marketing purposes without your written authorization.

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

CONTACT INFORMATION

If you have questions, would like additional information, or wish to exercise your rights, please contact:

Practice Name:	Willowbrook Dental Center
Address:	540 Willowbrook Rd, Columbus, MS 39705
Phone Number:	662-327-4523
Email (optional):	Willowbrookdentalcenter@gmail.com

PATIENT ACKNOWLEDGMENT OF NOTICE

By signing below, you acknowledge that you have received a copy of this Notice of Privacy Practices and understand your rights under HIPAA and applicable federal confidentiality laws, including special protections related to Substance Use Disorder (SUD) information.

- ☐ I acknowledge receipt of this Notice of Privacy Practices.
- ☐ I understand that SUD-related information may have additional protections.
- ☐ I understand my right to opt out of fundraising communications.
- ☐ I understand that certain disclosures may require my written authorization.
- ☐ Their SUD-related information cannot be used for fundraising without consent.

Patient Name (Print): _____

Signature: _____

Date: _____

If the patient is unable or unwilling to sign, staff should document the reason here.

Staff Initials: _____ Date: _____

If you believe your privacy rights have been violated, you may file a complaint with us or with OCR. You will not be penalized for filing a complaint.

Practice Privacy Officer:	Julie Howell
Practice Address:	540 Willowbrook Rd. , Columbus, MS 39705
Phone Number:	662-327-4523
Email (Opional):	Willowbrookdentalcenter@gmail.com