Kristin Rushing, DDS
5437 Edmondson Pike
Nashville, TN 37211
615-331-9033

Thank you for trusting us with your dental care.
Our goal is to provide quality dental services for the whole family in a professional and enjoyable environment.

PATIENT INFORMATION

Name _____ Birth date _____ SS#_____
Address _____ City, State _____ Zip_____
Sex ❑ Male ❑ Female
Status ❑ Single ❑ Married E-mail _____

Home Phone _____ Cell Phone _____ Other_____
Employer _____ Employer Phone _____
Employer Address_____ City _____ State_____ Zip_____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you?_____ Other Family Members seen by us _____
Emergency Contact_____ Phone _____

DENTAL Benefit INFORMATION

Primary Policy Holder_____
Employer _____
Policy Holders Birth date _____
Insurance Provider_____
Relation to Patient _____
Policy Holders SSN# _____
Currently a patient in our office? ☐ Yes ☐ No
Insurance Group/Plan #_____

MEDICAL Insurance INFORMATION (for policy holder only)

Name of Insured _____ Employer_____
Relation to Patient _____ Social Security #_____ Birth date _____
Insurance Company _____ Group # _____ What is your deductible?_____
Address_____ City_____ How much have you used? _____
State_____ Zip_____ Max. Annual Benefit_____

I authorize payment of insurance benefits directly to the Doctor otherwise payable directly to me. I authorize the release of any information relating to my dental services to my insurance company. I understand that dental benefits are not guaranteed and typically only cover a portion of treatment cost. I am responsible for all costs of treatment.

As a courtesy we will assist you with filing secondary insurance. Please bring all dental insurance cards to your appointment.

Signature of Patient, Parent or Guardian **Date**

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays_____

Check (✓) if you have or have had problems with any of the following:

- ❑ Sleep Apnea
- ❑ Snoring
- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or popping jaw (TMJ)
- ❑ Food collecting between the teeth
- ❑ Grinding Teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment / Deep cleanings
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Mouth Sores/ Ulcers

Would you like whiter teeth? ☐ Yes ☐ No
How often do you floss? _____
How often do you brush? _____
What type of toothbrush do you use? ☐ Soft ☐ Medium ☐ Hard
Do you smoke? How much? How Long? _____
Do you use smokeless tobacco? How much? How long?_____

MEDICAL HISTORY

Physician's Name _____ Date of last visit_____

Have you ever had any serious illnesses or operations? ☐ **Yes** ☐ **No** If yes, describe_____

(Women) Are you pregnant? ☐ **Yes** ☐ **No** Nursing? ☐ **Yes** ☐ **No** Taking birth control pills? ☐ **Yes** ☐ **No**

List medications, diet or herbal supplements you are currently taking:_____

_____

_____

Do you require Antibiotic Pre-Meciation prior to dental Procedures? ☐ **Yes** ☐ **No**

Have you been sedated for Dental work before? ☐ **Yes** ☐ **No** What sedation was used? ____Oral _____ IV

Check (✓) if you have or have had problems with any of the following:

- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves/ Transplant
- ❑ Artificial Joints, Pins, etc.
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart lesions
- ❑ Cortisone Treatments
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur or Mitral Valve Prolapse
- ❑ Heart Disease, Attack, Surgery, or Stent
- ❑ Hemophilia
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Latex
- ❑ None
- ❑ Other _____

CANCELLATION POLICY

We ask for at least 2 business days advance notice to change or cancel an appointment; otherwise, a $50 fee may be assessed to your account. A broken appointment is a loss to three people: the patient who missed the valuable time, the patient who could have taken that valuable time and the doctor who was fully staffed and prepared for the appointment.

I hereby agree to show up for my scheduled appointments on time and to give 2 business days advance notice if I need to cancel or reschedule an appointment.

For your convenience, our office uses an electronic confirmation and reminder system which utilizes email as well as text messages. The frequency of your reminders can be customized as well as the method of delivery. Please speak with our administrative staff in regards to your preferred option. Patients without electronic devices will receive a card and a personal call.

To the best of my knowledge, the above information is complete and correct.
***I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health*.**

Signature of Patient, Parent, or Guardian **Date**

Please print name of Patient, Parent, or Guardian **Relationship to Patient**

SMILE SURVEY

How do you feel about your smile? _____

If you could change anything about your smile, what would it be? _____

Is there anything that would keep you from improving your smile? If so, please explain.

_____

Are you familiar with how today's dentistry can enhance your smile? Yes / No
Would you like to learn more about how you can improve your smile? Yes / No
Would you like to know more about sedation dentistry? Yes/ No

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Financial Policy and Arrangements

Thank you for trusting us with your dental care. Our goal is to provide quality dental services for the whole family in a professional and enjoyable environment. Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment arrangements may be made to divide payments over the number of appointments. Cash and personal checks are accepted. If an extended payment plan is desired, please ask us about the CareCredit program. MasterCard and VISA credit card payment are also welcome. For charges of $500 or greater ask us about our in house Flex payment option or if 5% courtesy can be extended for full payment in advanced. If you have any questions, please feel free to ask.

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Should my account exceed sixty days, one and one-half percent (1.5%) interest per month (18% per year) will be charged. If the account is in default and turned over for collection, a collection fee will be added.

Dental Insurance Payments

Verification of benefits as well as filing your claim is a courtesy of our office. We may accept direct payment from most insurance companies and respect request that our patients Non-covered services, deductible and estimated patient portion will be paid at the time of service. We will estimate your deductible and the portion not covered by your dental plan to our best knowledge with the information that was provided to us. Due to insurance policy changes and/or benefit limitations or restrictions per individual, the estimated amount may vary from the actual paid amount for the services rendered. Your contracted rates are based on your current dental policy for the treatment rendered during that period. After termination or retro termination of your dental benefits, our regular fees will apply. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask.

All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

I acknowledge that I, not the insurance provider , am responsible for payment in Full for all services rendered.

Print Name Date

Signature

Notice of Privacy Practices

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.

PURPOSE: Nashville Smile Team, hereafter referred to as "Practice," follow the privacy practices described in this Notice. The Practice is required by law to maintain the privacy of your health information and to protect the integrity, confidentiality, and availability of your health information when it is collected, maintained, and transmitted. You may access or obtain a copy according to the following options: 1) our website at www.NashvilleSmileTeam.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment. This notice takes effect 1/22/15 and remains in effect until we replace it.

1. USES & DISCLOSURES OF PHI: Your PHI may be used and disclosed by our Practice's dentist, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you. This includes dental records, dental x-rays and payment information. This also includes information such as sensitive information including your social security number, credit card number, and other identifiable information in addition to sensitive medical information such as HIV status.

A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your dental care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.

B) Payment: We will use your PHI to obtain payment for the dental care services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.

C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff. i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement between our Practice and the business associate to assure the protection and privacy of your PHI. Business Associates are asked to disclose if they are working with subcontractors.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

D) **Required or Permitted by Law**: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

i) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.

ii) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.

iii) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

iv) Emails: Email and other electronic forms of communication may not be encrypted. Such email may compromise the security of your PHI. If you elect alternative forms of communication, please notify our office.

v) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.

B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include dental and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).

C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.

D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.

E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.

F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, you must submit your request in writing to the Privacy Officer.

G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.

H) Fundraising: If PHI is used for fund raising which is considered "health care operations," basic requirements must be satisfied to include notice to the individual and a process for individuals to opt-out. If the individual consents, only specific parts of PHI may be used for fund raising. Note: Your PHI will not be used in this manner at our Practice.

3. Complaints: You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days or as determined by this State when you knew that the act or omission complained of occurred. You may visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer. You will not be penalized for filing a complaint.

Nashville Smile Team - 5437 Edmondson Pike - Nashville, TN 37211 Telephone: (615) 331-9033, Fax: (615) 331-8140

Signature: Date: