# Office Policies

1. Our regular office hours are Monday through Friday, 8 am to 5 pm. We take our lunch break between 12 pm and 1 pm each day.

2. When we are out of the office, we have an answering machine for your convenience. Please leave your name, telephone number and a message if you desire and we will return your call as soon as possible.

3. Although we try to accommodate you as much as possible in the scheduling of your appointments, it is impossible to schedule them all in the afternoon hours.

4. Everyone loses when appointments are missed. You lose because it often takes four to six weeks to reschedule your appointment and that could mean longer treatment time than anticipated. The office loses because valuable treatment times needed for our patients are left vacant. Please give at least 24 hours notice in the change of any appointment. Failure to notify our office will result in a $25 charge.

5. Due to the nature of our practice, we strive to give our patients the very best care and service. This may result in your scheduled appointment being delayed a few minutes due to an emergency or unforeseen problem. We do value your time and are constantly trying to improve our scheduling and efficiency. If for some reason you need to be finished with your appointment by a certain time, please be sure to let us know when you arrive.

6. Loose bands and brackets not only increase appointment time, they often lengthen treatment times as well. Usually they are a result of something the patient has eaten, such as hard or sticky foods. After two loose bands or brackets, there will be an additional charge of $30 each.

7. Good hygiene is essential during orthodontic treatment. If your hygiene becomes a problem, we may decide to stain your teeth with a special plaque disclosing solution. This will show you the value of good brushing habits. We encourage you to visit your family dentist every six months for a routine check-up and cleaning.

8. We offer several payment options for your convenience in paying for orthodontic treatment. If you are set up on a payment plan with our office and your account becomes more than 90 days delinquent, the patient may be placed on hold and seen routinely during school hours for oral hygiene checks. No active treatment will be rendered until the account becomes current or other arrangements are made with this office. Any remaining balance on your account is due at the time treatment is complete (when braces are removed).

**Privacy Notice**

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 AND SIGN

Your protected health information (individually identifiable information such as names, dates, phones/fax numbers, email addresses, home addresses, social security number, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers in connection with our rendering orthodontic treatment to you (to determine the results of cleanings, surgery, etc.)
- To third party payers or spouses (insurance companies, employers with direct reimbursement, etc.) in order to obtain payment for your account (i.e. to determine benefits, etc.)
- To certifying, licensing, and accrediting bodies (i.e. the American Board of Orthodontics, State dental Board, etc.) in connection with obtaining certification, licensure, or accreditation.
- Internally, to all staff members who have any role in your treatment
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment: and/or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

**Under the new privacy rules, you have the right to:**

- Request restrictions on the use and disclosure of your protected health information
- Request confidential communication of your protected health information
- Inspect an obtain copies of your protected health information through asking us
- Amend or modify your protected health information in certain circumstances
- Receive and accounting of certain disclosures made by us of your protected health information
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contract person at our office address) or to the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation)

**Continued on Reverse Side**

**We have the following duties under the privacy rules:**

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information
- To abide by the terms of our privacy notice that is currently in effect
- To advise you of our right to change the terms of this privacy noticae and to make the new notice provisions effective for all protected health information maintained by us, and hat if we do so, we will provide you with a copy of the revised privacy notice.

**Please note that we are obligated to:**

- Honor any request by you to restrict the use or disclosure of your protected health information.
- Amend your protected health information if, for example, it is accurate and complete.
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for your Privacy Contract Person or direct your questions to this person at our office address. Thank you.

**Patient Acknowledgment**

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_______________________________________________________________________________

Patients signature (or parent of patient is under 18 years of age) Date

Date ____________

## Confidential Patient Information

Patient's name ________________________________________________
Last First

Address ________________________________________________
Street City State ZIP

Home phone ________________ Cell phone ________________ Birthdate _________________

How did you hear about us? ________________________________________________

## Confidential Responsible Party Information

Name ________________________________________ Marital status ____________
Last First

Address (if different than above)

________________________________________________
Street City State ZIP

How long at this address __________ Home phone ______________ Cell phone_ ______________

Previous address (if less than 3 yrs) ________________________________________________
Street City State ZIP

Social Security #_______________ Birthdate ______________ Relation to patient______________

Employer __________________ Occupation _________________ No. of years employed________

Spouse's Name ____________________________________
Last First

Employer __________________ Occupation _________________ No. of years employed________

Social security # ________________ Birthdate ______________ Work phone __________________

## Insurance Information

Policy holder's name ___________________________________ SS# _____________________

Policy holder's birthdate __________________ Policy holder's employer _____________________

Insurance company ________________________________ Insurance phone __________________

**ASSIGNMENT OF INSURANCE BENEFITS**: I hereby authorize and request my insurance company to pay directly to Couser Orthodontics the amount on any claims for service rendered on myself or dependent. I further agree that should the amount be insufficient to cover the entire expense, I shall be responsible for the difference, and if the insurance policy does not cover any amount, for any reason, I will be responsible to Couser Orthodontics for payment of the entire bill.

**Primary Insured X**___________________________________ Date: ___________________

**Please continue on reverse side**

## Patient Health History

Is the patient presently under a physician's care? ________________________________________

If yes, explain: ________________________________________________________________

Has the patient ever had a reaction or is he/she allergic to any of the following: (circle if YES)

| | |
|---|---|
| Aspirin | Penicillin |
| Codeine | Barbiturates |
| Dental Anesthetic | Other (list) ________________________ |

Has the patient ever had any of the following? (circle if YES)

| | | |
|---|---|---|
| Heart trouble | Tuberculosis | Radiation treatment |
| Ulcers | Hepatitis | Epilepsy or convulsions |
| Kidney disease | Rheumatic fever | High blood pressure |
| Venereal disease | Diabetes | Stroke |
| Thyroid trouble | Asthma | Breathing problems |
| Tumor or growth | Jaundice | Tonsils and/or adenoids removed |

Is the patient taking any bisphosphonates (fosamax, boniva, actonel, zometa or didronel) for osteoporosis? ___________________

Does the patient smoke? _________ If yes, how often? _____________________

Is the patient subject to prolonged bleeding? ________________

Patient's dentist ___________________________ Dentist phone number _____________________

When was the patient's last dental visit? ___________________________

Has there been any injury to the face, mouth or teeth? _____________________________________

Has the patient had a history of thumb sucking or finger sucking? _________ Until what age? ____

Have you been informed of any missing or extra permanent teeth? ____________________

Have you consulted an orthodontist previously? ____________________________

Has the patient had any previous orthodontic treatment? ______________________________

I agree to be fully responsible for total payment of procedures performed in this office including any amounts which are not covered by any dental insurance company that I may have. I certify that the above information is complete and accurate. I further understand that the information provided may be used to obtain a credit report and my individual credit worthiness may be considered when making a decision to offer credit for services rendered.

**Responsible party signature** _________________________________ Date ____________________