

WELCOME TO DERRY ORTHODONTICS, P.L.L.C.

Thank you for downloading our new patient forms which will provide us with important information about you or your child and provide you with important information about our privacy practices.

Please print these forms, complete the required fields and bring them with you to your first appointment. If your child is the patient, please review and complete pages 2 and 4 to 8. If you are the patient, please review and complete pages 3 to 8.

We are looking forward to meeting you!

WELCOME TO DERRY ORTHODONTICS, P.L.L.C.

TELL US ABOUT YOUR CHILD

Today's Date: _____
Name: _____
Nickname: _____
D.O.B.: _____ Age: _____
Home Address: _____

City State Zip Code
Other Siblings (Ages): _____
Interests/Hobbies/Sports: _____

GENERAL INFORMATION

Who is accompanying the child today? _____
Relation: _____
Do you have legal custody? Yes [] No []
Whom may we thank for referring you? _____
General Dentist: _____
General Dentist's Tel.: (____)____-____ Last Appt _____
Emergency Contact Person: _____
Relation to Child: _____
Emergency Contact Tel.: (____)____-____

PARENT OR GUARDIAN INFORMATION

Person responsible for account: _____
Father [] Stepfather [] Guardian []
Name: _____ D.O.B.: _____
Address: _____ Home Tel.: (____)____-____

City State Zip Code
SSN: _____-____-____
Work Tel.: (____)____-____ Cell: (____)____-____
E-Mail: _____
Employer: _____
Occupation: _____
Employer Address: _____

City State Zip Code

Marital Status: Single [] Married [] Guardian []
Mother [] Stepmother [] Guardian []
Name: _____ D.O.B.: _____
Address: _____ Home Tel.: (____)____-____

City State Zip Code
SSN: _____-____-____
Work Tel.: (____)____-____ Cell: (____)____-____
E-Mail: _____
Employer: _____
Occupation: _____
Employer Address: _____

City State Zip Code

ORTHODONTIC INSURANCE

Insurance Co.: _____
Insurance Co. Address: _____

City State Zip Code
Tel.: (____)____-____
Insured's ID No.: _____
Group No. (Plan, Local or Policy No.): _____

Insurance Co.: _____
Insurance Co. Address: _____

City State Zip Code
Tel.: (____)____-____
Insured's ID No.: _____
Group No. (Plan, Local or Policy No.): _____

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the orthodontist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Primary Signature

Date: _____

Secondary Signature

Date: _____

OFFICE USE ONLY

Lifetime Maximum at %: _____
Limitations: _____
Deductible: _____
Non-Duplicating Clause: Yes [] No []
Date Effective: _____

WELCOME TO DERRY ORTHODONTICS, P.L.L.C.

ABOUT YOU

Date: _____
Name: _____ D.O.B.: _____
Age: _____ SSN: _____-____-_____
Home Address: _____

City _____ State _____ Zip Code _____
Billing Address: _____

City _____ State _____ Zip Code _____
Single [] Married [] Divorced [] Separated []
Home Tel.: (____) _____-____-____ Cell: (____) _____-_____
E-Mail: _____
Employer: _____
Occupation: _____ Years Employed: _____
Employer Address: _____

City _____ State _____ Zip Code _____
Work Tel.: (____) _____-____-____

Whom May We Thank for Referring You? _____
Other Family Members Treated by Dr. Caldwell:
General Dentist: _____
Address: _____

City _____ State _____ Zip Code _____

SPOUSE INFORMATION

Name: _____ D.O.B.: _____
Age: _____ SSN: _____-____-_____
Home Tel.: (____) _____-____-____ Cell: (____) _____-_____
Employer: _____
Occupation: _____ Years Employed: _____
Employer Address: _____

City _____ State _____ Zip Code _____
Work Tel.: (____) _____-____-____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
Billing Address: _____

City _____ State _____ Zip Code _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____
Home Tel.: (____) _____-____-____ Cell: (____) _____-_____
Work Tel.: (____) _____-____-____

AUTHORIZATION

I authorize Derry Orthodontics, P.L.L.C. to disclose my personal information to credit reporting agencies for the purpose of obtaining information about my credit rating prior to offering in-house financing of orthodontic treatment and fees. I agree to pay for the orthodontic treatment and related fees which may be applied to my account for broken or missed appointments and to pay any co-payment and/or deductibles that my insurance policy will not pay. I further authorize Derry Orthodontics, P.L.L.C. to release all information which is necessary to make submissions for payment to my insurance company. Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Primary Signature: _____ Date: _____

Secondary Signature: _____ Date: _____

ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage? Yes [] No []
Insurance Co.: _____
Insurance Co. Address: _____

City _____ State _____ Zip Code _____
Tel.: (____) _____-____-____

Insured's Name: _____ D.O.B.: _____
Insured's Relation to You: _____
Insured's ID No.: _____
Group No. (Plan, Local or Policy No.): _____
Insured's Employer: _____
Employer Address: _____

City _____ State _____ Zip Code _____
Work Tel.: (____) _____-____-____

SECONDARY

Orthodontic Coverage? Yes [] No []
Insurance Co.: _____
Insurance Co. Address: _____

City _____ State _____ Zip Code _____
Tel.: (____) _____-____-____

Insured's Name: _____ D.O.B.: _____
Insured's Relation to You: _____
Insured's ID No.: _____
Group No. (Plan, Local or Policy No.): _____
Insured's Employer: _____
Employer Address: _____

City _____ State _____ Zip Code _____
Work Tel.: (____) _____-____-____

OFFICE USE ONLY

Lifetime Maximum at %: _____
Limitations: _____
Deductible: _____
Non-Duplicating Clause: Yes [] No []
Date Effective: _____

WELCOME TO DERRY ORTHODONTICS, P.L.L.C.

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of the receipt of this Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 14 April 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.10 for each page, \$35.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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

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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.

Contact Officer: Brenda Caldwell

Telephone: (603) 434-6433

Fax: (603) 434-6133

E-mail: smile@derryorthodontics.com

Address: 4 Peabody Road Annex

Derry, New Hampshire 03038

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WELCOME TO DERRY ORTHODONTICS, P.L.L.C.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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

Signature: _____ Date: _____

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 (Please Specify)

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: In cases where Dr. Caldwell has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

City _____ State _____ Zip Code _____
Tel.: (_____) _____ - _____

E-mail: _____

Patient Number: _____ SSN: _____ - _____ - _____

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 have the right to 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 reserve 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 Officer: Brenda Caldwell
Telephone: (603) 434-6433
Fax: (603) 434-6133
E-mail: smile@derryorthodontics.com
Address: 4 Peabody Road Annex
Derry, New Hampshire 03038

Right to Revoke: You 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 to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**