

**BALDWIN COUNTY
ENDODONTICS**

ACQUAINTANCE SLIP

Christopher S. McManus, D.M.D.

Patient's Name _____ Date of Birth _____

Address _____ Phone _____

City & State _____ Zip Code _____

Employer _____ Dept. _____

Employer's Address _____

_____ Phone _____

Your Social Security # _____

Does your employer provide Dental Insurance? _____

If so, Name of Ins. Co. _____

Policy # _____

Spouse's or parent's Name _____

Employed by _____ Dept. _____

Employer's Address _____

_____ Phone _____

Social Security # _____ Does this employer provide dental ins.? _____

If so, Name of Ins. Co. _____

Policy # _____

Birthdate of Insured _____

PLEASE TURN TO BACK OF THIS SHEET TO ANSWER THE REQUIRED MEDICAL QUESTIONS.

HEALTH HISTORY

Information about your health will be held as confidential by this office and will be released upon your expressed consent. Many general health factors may affect your oral health and influence our treatment. Therefore, it is important for you to complete this form accurately and in its entirety. Thank you.

1. General health? Excellent Good Fair Poor

Physician's name _____

2. Please circle any of the following you have or have had:

Artificial Heart Valve	Heart Murmur	Asthma	Fainting
Prosthetic Implants	High Blood Pressure	Diabetes	Nervous Disorder
Mitral Valve Prolapse	Hepatitis	Liver Disease	Prolonged Bleeding
Rheumatic Fever	Tuberculosis	Kidney Disease	Heart Attack
AIDS/HIV	Cancer/Malignancy	Radiation Treatment	Epilepsy or Seizures

YES NO

3. Have you had or do you have any medical problem NOT mentioned above? YES NO

(If yes, please describe.) _____

4. Are you now being treated by a physician? YES NO

5. Do you take any drug/medication for your tooth or a medical problem? YES NO

If yes, please list: _____

6. Are you allergic to penicillin, codeine or any other drug? YES NO

If yes, please list: _____

7. Have you experienced an unfavorable reaction from any previous

dental treatment? YES NO

8. Have you ever had Root Canal Treatment? YES NO

FEMALES:

9. Are you pregnant? YES NO

Patient's
Signature _____ Date _____

If the patient is a minor:

Parent's Signature _____

I give permission for examination and endodontic treatment for my minor child, named above.

PATIENT FINANCIAL AGREEMENT & RELEASE OF INFORMATION

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. PAYMENT. Payment of any unmet deductible, co-insurance, co-payment, and any charges not covered by insurance is expected at the time of your visit. We accept cash, check and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service

2. INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE.

- It is your responsibility to confirm which treatments or procedures are covered and/or paid by insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
- As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. In order to bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
- We can only approximate the percentage covered by each plan. Payment of the ESTIMATED portion as well as your co-payment is due at time of service.
- Any estimate of insurance coverage may differ from what your insurance carrier ultimately pays. You will be responsible for any charge that insurance determines to be not covered.
- ****NOTE:** If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service,
- As the parent or guardian accompanying a minor, you are financially responsible for all charges, whether or not paid by insurance.
- In situations of divorce, separation, court orders, etc., the adult who signs in a minor child on the day of treatment accepts financial responsibility for payment.
- Non-covered procedures will not be filed to insurance.
- Medicare does not cover in-office general anesthesia or dental related procedures including extractions.
- Adults 21 years of age and older are not eligible for dental coverage through Medicaid.

- Private pay/uninsured patients must pay in full at time of service.

3. BILLING AND COLLECTION

- Returned checks will be subject to a fee of up to \$30.00, except where prohibited by law.
- Payment is due as stated on any billing statement mailed, emailed or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past-due.
- Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
- Past due accounts may be placed with a collection agency or attorney for collection.
- In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees, reasonable attorney's fees and expenses, collection expenses, and court costs.
- If your account is turned over for collections, you will no longer be able to receive services from the Practice until your delinquency is cured.

4. CONSENT TO CONTACT. The Practice may contact you for any purpose and in any manner permitted by law. You also expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the Practice, and anyone contacting you on our behalf, may communicate with you in any manner, including through the use of an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

I have read the financial policies above, and my signature below indicates my agreement to these policies and acceptance of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any services provided to me, I assume financial responsibility and will pay all such charges in full.

I hereby authorize the Practice to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Practice all insurance benefits otherwise payable to me for the Practice's services.

Patient Name

Patient DOB

Patient or Responsible Party Signature

Date

Printed Name of Responsible Party
(if applicable)

Relationship to Patient
(if applicable)



1. The purpose of root canal therapy is to retain teeth that otherwise would have to be extracted (pulled).
2. Treatment will require a series of x-rays and may require multiple visits. It is important that you keep scheduled appointments, or infection may reoccur.
3. In most cases, there is only mild discomfort after treatment. This usually lasts 2-4 days and is usually controlled by Ibuprofen, aspirin, Tylenol or a prescribed medication.
4. Endodontic therapy has a high rate of success (approximately 90-95%). However, as with any medical or dental treatment, there is no guarantee of success for any length of time.
5. Most common complications include but are not limited to:
 - a. Continued infection requiring Endodontic surgery or tooth extraction at an additional cost.
 - b. Calcified canals or canals blocked by separated instruments requiring Endodontic surgery or tooth extraction at an additional cost.
 - c. Pain requiring use of medications.
 - d. Fracture (breaking) of the root or crown of the tooth during or after treatment. It is recommended that teeth be crowned (capped) following root canal treatment. If your tooth already has a crown it may have to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage and may also have to be replaced.
 - e. Side effects and possible reactions to medications.
 - f. Tenderness of the tooth following treatment, due to possible complications with root canal treatment, gum disease, physical stress from chewing or the degree of healing your body exhibits.
6. The restoration of your tooth (filling, crown, etc.) will be performed by your General Dentist (our fee does not include these services).
7. Other treatment choices include:
 - a. No treatment
 - b. Waiting for more definite development of symptoms
 - c. Tooth extraction (pulling).***Risks involved in these choices may include pain, infection, swelling, loss of teeth and possible spread of infection to other areas.
8. If you have any questions please ask!

"I have read and understand the above information, and understand the possible risks involved, and hereby consent to treatment."

Signature of Patient or Parent

Date

Staff

Date

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ENDODONTICS**

Christopher S. McManus, D.M.D.

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

*** You May Refuse to Sign This Acknowledgement ***

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

Please Print Name

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)



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 ___/___/___, 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.

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 practically 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.____ for each page. \$____ 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 of 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 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: _____
Telephone: _____
Fax: _____
E-mail: _____
Address: _____