BALDWIN COUNTY ENDODONTICS

Christopher S. McManus, D.M.D.

ACQUAINTANCE SLIP

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 confidental by this office and will be released upon your expressed consent. Many general health factors may affect your oral heallh 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?	❑	❑

(If yes, please describe.) ______________________________

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	YES	NO
4. Are you now being treated by a physician?	❑	❑
5. Do you take any drug/medication for your tooth or a medical problem?	❑	❑

If yes, please list: ______________________________

____

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

If yes, please list: ______________________________

____

	YES	NO
7. Have you experienced an unfavorable reaction from any previous dental treatment?	❑	❑
8. Have you ever had Root Canal Treatment?	❑	❑

FEMALES:

	YES	NO
9. Are you pregnant?	❑	❑

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.

BCE002

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, debit card, and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service. **Please note that payments made by credit card will incur a 3% surcharge.**

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.
- Private pay/uninsured patients: (i) you must pay in full at time of service, and (ii) you hereby acknowledge receipt of a Good Faith Estimate as required by 45 C.F.R. §149.610 by signing below.

3. BILLING AND COLLECTION.

- 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 (either 33.33% of the amount due or the maximum amount allowed by applicable law), reasonable attorney's fees and expenses, collection expenses, and court costs. If your account is turned over to collections, you hereby accept any such fees and costs as a legal and lawful debt and agree to paid said fees, including any and all resulting fees and costs. You hereby waive your right of exemption under any applicable laws.
- 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 and anyone contacting you on our behalf 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 and/or anyone contacting you on our behalf 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)

(Version 08.2024)

CONSENT FOR ROOT CANAL THERAPY, ENDODONTIC SURGERY, ANESTHETICS AND MEDICATION

You will be required to sign this form prior to the initiation of treatment. Although endodontic (root canal) therapy has a high degree of success, results cannot be guaranteed. On occasion, a tooth which has had root canal therapy may require retreatment, surgery or even extraction. While serious complications with endodontic (root canal) therapy are uncommon, we want you as our patient to be informed about the various procedures involved and have your consent before starting any treatment. Endodontic therapy is performed to retain a tooth that otherwise might require extraction. This is accomplished by root canal therapy or endodontic surgery. Accurate and complete disclosure of the patient's current and past medical information, including allergy history, is needed for proper diagnosis and treatment. The following describes possible risks involved with endodontic therapy and other treatment choices.

Risks: Include, but are not limited to, complications resulting from the use of dental instruments and supplies, drugs, sedation, medicines, analgesics and injections. These complications may include, without limitation, swelling, sensitivity, bleeding, pain, infection, temporary or permanent numbness and tingling sensation in the lip, tongue, cheek, gums and teeth (very infrequent complications from injections), changes in occlusion (bite), jaw muscle cramps and spasms, TMJ difficulty, loosening of teeth, referred pain to ear, neck or head, nausea, vomiting, allergic reaction, delayed healing, sinus perforation, and treatment failure.

Risks Specific to Endodontic Therapy: Include, but are not limited to, the possibility of instruments separating or breaking within the root canal, perforations (extra openings) of the crown or root of a tooth or sinus, damage to bridges, dentures, crowns, existing fillings or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications could arise which make treatment impossible or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, separated instruments, curved root, periodontal (gum) disease and splits or fractures of the teeth. Treatment will require a series of diagnostic radiographs and, in some cases, may require more than one visit to your endodontist.

Medications: On occasion, medications or drugs may be prescribed by your endodontist. Medications used and/or prescribed for discomfort and/or sedation may cause drowsiness or lack of awareness and coordination, which can be increased by the use of alcohol, tranquilizers, sedatives or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking or under the influence of such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, please call your endodontist or your endodontist's office and staff immediately.

Other Treatment Options: There are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include, without limitation, no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

It is the patient's responsibility to report any changes in his/her medical history to his/her endodontist.

As a specialty practice, this office performs only endodontic therapy and associated surgery. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. It is important that you follow up with your general dentist promptly following endodontic treatment for permanent restoration and care. Failure to do so within 30 days of your endodontic treatment could cause complications, such as infection of the treated tooth leading to the need for further endodontic treatment or extraction of the tooth.

Consent: By signing below, I acknowledge that I fully understand the statements and information in this consent form.

______________________________	______________________________
Patient Name (Printed)	Patient DOB
______________________________	______________________________
Patient or Responsible Party Signature	Date
______________________________	______________________________
Printed Name of Responsible Party (if applicable)	Relationship to Patient (if applicable)

BALDWIN COUNTY ENDODONTICS

Christopher S. McManus, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement *

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)

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BALDWIN COUNTY ENDODONTICS

NOTICE OF PRIVACY PRACTICES

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,)rou 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 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.___ 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 ol 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. Il 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: ______________________

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