

Damon T. Armstrong D.D.S., Wilson R. Armstrong D.D.S.

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 January 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 by 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 qualification 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 to disclose 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 the use or disclosures permitted by our authorization while it was in effect. Unless you give us 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 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, or 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 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 care 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 authorize federal officials health information required for lawful intelligence, counter intelligence, 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 voice mail 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

\$.35 for each page. \$10.00 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 and/or explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation for 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 past 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 alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation of how your payment 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 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 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: 208-785-3310

Fax: 208-785-3393

E-mail: armstrongdental@yahoo.com

Address: 625 W Pacific #4, Blackfoot, Idaho 83221

Damon T. Armstrong D.D.S., Wilson R. Armstrong D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

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 acknowledgment

_____ an emergency situation prevented us from obtaining the acknowledgement

_____ Other (Please Specify)



Patient Information

Patient Name: _____ Date: _____

Social Security # _____ Birth Date: _____ Family Status: _____

Phone: (Home) _____ (Work) _____ (Cell) _____ (Daytime) _____

E-Mail _____ Best Way to Contact you: Phone, E-Mail, Text _____

Address: _____

City: _____ State: _____ Zip Code: _____

Health Information

Date of Last Dental Visit: _____ Reason for this Visit: _____

Have you had any of the following – Please check those that apply

<input type="checkbox"/> Aids	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Tumors
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Growths	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pregnancy – Due Date: _____	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Respiratory Problem	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Problems

- ❖ Have you ever had any complication following dental treatment? Yes No
If Yes, Please explain: _____
- ❖ Have you been admitted to a hospital or needed emergency treatment during the past two years? If yes, Please explain:

- ❖ Are you now under the care of a physician? If yes, Please explain

- ❖ Physician name: _____ Physician Phone # _____
- ❖ Do you have any health issues that need further clarification:

- ❖ Are you taking any medications? If yes, please list the medications you are taking:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Responsible Party Information

The following is for the person responsible for payment

Name: _____ Birth Date: _____

SS#: _____ Phone (Home) _____ (Work) _____ (Cell) _____

Address: _____

Employment Information

The following is for the patient _____ Person responsible for payment _____

Employer Name: _____ Occupation: _____

Insurance Information

Primary Insurance:

Name of Insured: _____ Is Insured a patient Yes ___ No ___

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address: _____

Insured's Employer Name: _____

Patient's relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

Insurance Plan Name and Address: _____

Secondary Insurance:

Name of Insured: _____ Is Insured a patient Yes ___ No ___

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address: _____

Insured's Employer Name: _____

Patient's relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Release for Use of Images

I hereby give my consent to Armstrong Dental to photograph and then use, reproduce, and publish said images of me and/or my child/children.

(Please print name)

(Please print child's name)

I agree that photographs/negatives thereof shall constitute the sole property of Armstrong Dental, with full right of disposition in any manner whatsoever, including the right to publish on their website damonarmstrongdds.com.

I hereby release Armstrong Dental and his/her legal representatives and assigns from any and all claims whatsoever in connection with the use, reproduction, publication of the images thereof.

_____ Date: _____
Signature

_____ Date: _____
Signature for minor child

_____ Address _____ Phone: _____