General Office Policy Note

Welcome to our practice. We take great pride in providing top quality comprehensive care for our patients. To do this, we carry out an extensive initial evaluation for routine patients. We also perform periodic examinations that include the necessary x-rays (in general: bitewing and anterior periapical films every 6 months, panoramic films every 3 years), periodontal examination (generally once a year), and clinical evaluation. The recommended times for x-rays and periodontal examination will vary depending on the clinical findings and history of each patient.

Patients that are in pain requiring immediate evaluation will be offered a same day appointment. Every effort will be made to provide treatment at that same visit; however, there may be times that we will need a scheduled appointment for the necessary treatment.

We understand that your time is as valuable as ours, so we ask that you adhere to your given appointment time. When patients are late to their scheduled appointments, they cause a domino effect that will, at times, affect the rest of the patients for that day. We ask that if you are going to be more than 10 min late for an appointment you understand that we will, in all probability, need to reschedule your appointment.

We respect your privacy and will not discuss your treatment with anyone unless you have given us express consent. So please be sure to advise the front desk if there are any third parties you wish to have information regarding your treatment and/or the associated costs thereof. They will be happy to provide you with a form you can sign allowing us to do so.

We keep current with OSHA, American Dental Association, and Centers for Disease Control and Prevention (CDC) recommendations on all aspects of patient care including our sterilization protocol.

We treat you as we would ourselves and our family and welcome any questions, comments and/or concerns you may have regarding any aspect of your care or of our office policies.

Date:_____________

Signature:___________________________________

Printed name:________________________________

FERGUSON DENTAL P.A.

Rick & Katherine Ferguson D.M.D.

FINANCIAL AGREEMENT:

The undersigned agrees he/she is hereby obligated and agrees to pay Dr.Ferguson's charges for services rendered by said Doctor. I further agree that payment is due upon receipt of invoice/statement I understand that unpaid accounts will be considered in default after thirty (30) days, after which time interest will be imposed at the rate of 1-1/2% per month on unpaid balances (ANNUAL PERCENTAGE RATE OF 18%) or the legal interest rate, which ever is lower In the event a legal suit or outside collections are necessary to enforce payment of this account, I agree to pay 25.0% of the principle balance for attorneys' fees and court costs or collection fees. The patient/guarantor waives venue jurisdiction and submits itself to the jurisdiction and venue of the State Courts of Broward County, Florida.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment to be made directly to Dr. Ferguson for benefits which may be due and payable under insurance coverage for the above named patient Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct, and request that said payment of authorized benefits be made payable on my behalf to Dr. Ferguson. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Dr Ferguson.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION:

Dr. Rick or Katherine Ferguson is hereby authorized to disclose all or any part of the medical/dental records on the above named patient to such insurance companies. organizations, or agencies as may be responsible for payment of services rendered by Dr. Rick Ferguson. Likewise my insurance company(s), organizations or agencies responsible for payment is hereby authorized to disclose all or any medical/dental records to Dr. Rick Ferguson which includes treatment for Drug and Alcohol Abuse, Mental Health, HIV Virus and Sexual Assault. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by Dr Rick Ferguson or Dr. Katherine Ferguson.

MISSED APPOINTMENTS:

I agree, unless my scheduled appointment is canceled at least 24 hours in advance, that I am liable to pay the broken appointment fee of $15/quarter hour scheduled.

X-RAY EXAMINATION (FOR FEMALES ONLY):

I am aware that the radiation exposure may be harmful to an unborn child. To the best of my knowledge, I am not pregnant at the time. I agree to diagnostic x-ray examinations as requested by Drs. Rick or Katherine Ferguson.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS EACH OF THE ABOVE PARAGRAPHS AND IS THE PATIENT OR RESPONSIBLE PARTY WITH THE POWER TO EXECUTE THIS DOCUMENT AND ACCEPT THESE TERMS.

Signature of Patient or Responsible Party & Date ____________________

Signature of Witness ____________________

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 3/20/2003, 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.

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 $0.75 for each page, $ 20.00 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 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: Rick Ferguson DMD

Telephone: 954-530-5164 Fax: 954-208-8080

E-mail: Fergusonsdental@aol.com

Address: 4745 SW 148th Ave. Suite 302, Davie, FL 33330

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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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I, (print name) ____ , hereby authorize

Dentists Dr. Rick and/or Katherine Ferguson to perform a local anesthetic injection(s).

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which can not be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent, may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all of my questions answered.

____
Patient's Signature

____
If a Minor, Signature of Parent Or Guardian

____
Witness Signature

____
Dentist/Hygienist/Other Signature

____
Date

CONSENT FOR LOCAL ANESTHETIC INJECTIONS

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