TODAY'S FAMILY DENTISTRY

Rebecca L. Baker, DMD
GENERAL CONSENT FORM

CONSENT TO TREATMENT

I do hereby authorize and request the performance of dental services and the use of whatever procedures Dr. Baker or one of her associates may deem necessary for treatment. I understand that Dr. Baker or one of her associates and their staff will use clinical and patient management techniques that are reasonable, necessary, and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed appropriate by Dr. Baker or one of her associates. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic, or the treatment of facial pain. I understand that potential complications include, but are not limited to, pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged, and in very rare cases permanent.

I understand that I am responsible for attaining any current x-rays that may have been taken at a previous office. If I do not obtain them, I permit the retaking of any necessary x-rays.

I understand that any treatment plans presented, along with fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. Dr Baker or one of her associates, or their staff will always advise me of any changes.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

In the event that Dr. Baker or one of her associates, or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn tested for Hepatitis B virus (HBV), Hepatitis C virus (HVC), and the human immunodeficeincy virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

I agree to be responsible for all of the charges for the dental services and materials not paid by dental benefit plan, unless the treating dentist has a contractual agreement with a plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize the release of any information relating to this claim.

If dental insurance is filed, I hereby authorize payment of the dental benefits otherwise payable to me to Dr. Rebecca Baker.

_____
Printed Patient/Guardian Name

_____
Patient/Guardian Signature/Date

TODAY'S FAMILY DENTISTRY

FINANCIAL POLICY

Dental treatment is an excellent investment in an individual's physical and psychological well being. Our office is committed to providing you with the best health care possible. In order to achieve this goal, we need your assistance and understanding of our financial policy.

As a health care provider, we must emphasize that our relationship is with you, not with your dental insurance company. You are ultimately responsible for your account. If you have dental insurance, we will do our best to help you receive your maximum allowable insurance benefits, but we have no control over those benefits.

Additionally, financial considerations should not be an obstacle to obtaining important health care treatment. We recognize that not all of our patients have dental insurance. We are sensitive to your varying needs and financial obligations.

In order to better serve you, we have prepared several payment options to provide you with the flexibility that you deserve:

- SELF PAY- **You are responsible for your fees at the time of service.** For your convenience, we accept cash, personal checks, Visa, MasterCard, and Discover.

- DENTAL INSURANCE- You and your insurance company share the responsibility for your fees and **your portion is due at the time of service.** We will submit your claim and receive payment from your insurance company for services provided. We will contact your insurance on your behalf so that we may provide you with an **estimate** of the portion of your fees due at the time of service. You must realize, however, that all charges are ultimately your responsibility. Most dental insurance plans do not cover all services in full. We cannot be held responsible if in fact there is no insurance coverage for the procedure(s), or if your insurance company refuses payment at a later date. Furthermore, some portion or all of your benefits may be used for the plan year.

- CARE CREDIT AND CITI HEALTH- You are responsible for your fees at the time of service and you can finance those fees with Unicorn Financial with no initial payment. Care Credit and Citi Health pays Dr Baker on your behalf for services rendered and you pay Care Credit or Citi Health monthly payments.

PLEASE NOTE: In addition to all outstanding balances the patient acknowledges and agrees to pay all reasonable collection fees and legal fees. This authorization remains valid unless revoked in writing.

Signature:_____

Date:_____

Effective Date 6/24/13

Today's Family Dentistry
Rebecca L. Baker, DMD, PSC
HIPPA 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 READ IT CAREFULLY.

The Dental Practice Covered By This Notice

This notice describes the privacy practices of Today's Family Dentistry. "We" and "our" means the dental practice. "You" and "your" means our patient.

How to Contact Us/Our Privacy Official

Today's Family Dentistry
Amber Mullins
107 Frazier Court Suite 2E
Georgetown, KY 40324
todaysfamilydentistry@gmail.com
(502)863-3600

Information Covered By This Notice

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- maintain the privacy of your health information;
- give you this Notice of our legal duties and privacy practices with respect to that information; and
- abide by the terms of our Notice that is currently in effect.

Our Use and Disclosure of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment. We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you. In the event that you pay in full, out of pocket, for services, you now have the right to request for our office not to disclose treatment information for this service to a health plan.

Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and

services that may be of interest to you.

Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with you care or payment for your care if you do not object, or if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information
The following uses and disclosures occur infrequently and may never apply to you.

Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPPA.

Public Health Activities. We may disclose patient health information for public health activities and purposes, with include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions. We may disclose patient health information is response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes. We may disclose patient health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation. We may use or disclose patient health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes. We may use and disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety. We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions. We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about it inmates.

Workers' Compensation. We may disclose patient health information to comply with workers'

compensation laws or similar programs that provide benefits for work-related injuries or illness.

Fundraising and/or Marketing
If your protected health information is used for fundraising and/or marketing, you will be given the option to opt out. If there is a disclosure of private health information for fundraising and/or marketing purposes a written authorization must first be obtained. In the event of a breach of private health information, you will be notified immediately.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in the Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reason covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information is a Designated Record Set as defined by HIPPA). To exercise any of these Rights, you must submit a written request to our Privacy Official listed on the first page of the Notice.

Access. You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend. If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure. You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment of your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternatives Means, Alternatives Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact of alternative address and indicate how payment for services will be handled.

Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPPA). The first accounting we provide in any 12 month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12 month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice
We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints
If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way of you choose to file a complaint.

Patient Name:_____

Patient Signature:_____