Thank you for scheduling a new patient appointment at Hillcrest Dental Care.

Enclosed is our new patient packet, if you could please be sure to complete the front and back of each sheet and bring it to your committed appointment time along with your current insurance card and a picture id.

We ask that you **arrive 15 minutes early** to your appointment time to allow staff time to enter your information into our practice management system and verify any insurance coverage you might have.

What to expect at your new patient appointment:

We will perform a comprehensive exam and a full mouth set of x-rays*. The dentist will discuss with you what your treatment needs are and at that time you will both create a treatment plan that meet your specific needs and goals.

Any needed treatment along with your cleaning will be schedule after this visit.

> ***If you have current x-rays please contact your previous dental office and bring these to the appointment with you.**

We look forward to meeting you!

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	

Address: PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE

Phone: Home / Work — Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other____________
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician ______________________________ Phone ______________

Child's History

Yes No

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? .... 1. ❑ ❑
   If yes, please list: ______________________________
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: __________ 2. ❑ ❑
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: __________ 3. ❑ ❑
4. How would you describe the child's eating habits? ______________________________
5. Has the child ever had a serious illness? If yes, when: __________ Please describe: __________ 5. ❑ ❑
6. Has the child ever been hospitalized? .... 6. ❑ ❑
7. Does the child have a history of any other illnesses? If yes, please list: __________ 7. ❑ ❑
8. Has the child ever received a general anesthetic? .... 8. ❑ ❑
9. Does the child have any inherited problems? .... 9. ❑ ❑
10. Does the child have any speech difficulties? .... 10. ❑ ❑
11. Has the child ever had a blood transfusion? .... 11. ❑ ❑
12. Is the child physically, mentally, or emotionally impaired? .... 12. ❑ ❑
13. Does the child experience excessive bleeding when cut? .... 13. ❑ ❑
14. Is the child currently being treated for any illnesses? .... 14. ❑ ❑
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: __________ 15. ❑ ❑
16. Has the child had any problem with dental treatment in the past? .... 16. ❑ ❑
17. Has the child ever had dental radiographs (x-rays) exposed? .... 17. ❑ ❑
18. Has the child ever suffered any injuries to the mouth, head or teeth? .... 18. ❑ ❑
19. Has the child had any problems with the eruption or shedding of teeth? .... 19. ❑ ❑
20. Has the child had any orthodontic treatment? .... 20. ❑ ❑
21. **What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water
22. **Does the child take fluoride supplements?** .... 22. ❑ ❑
23. **Is fluoride toothpaste used?** .... 23. ❑ ❑
24. How many times are the child's teeth brushed per day? ________ When are the teeth brushed? __________ 24. ❑ ❑
25. Does the child suck his/her thumb, fingers or pacifier? .... 25. ❑ ❑
26. At what age did the child stop bottle feeding? Age ________ Breast feeding? Age ________
27. Does child participate in active recreational activities? .... 27. ❑ ❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature ______________________________ Date ______________

For completion by dentist
Comments ______________________________

____

____

____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by ______________________________
Date ______________________________

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Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Hillcrest Dental Care, Inc.
Committed

PATIENT REGISTRATION FORM

____
Name: First MI Last

Date of Birth: ______________ Male_____ Female_____

Race:

___Caucasian ___American Indian/Alaska Native

___Asian ___Black/African American

___Native Hawaiian or other Pacific Islander

Ethnicity:

___Hispanic / Latino ___Not Hispanic/Latino ___Other

Annual Household Income:

___ $0 - 19,999 ___$20,000 - $39,999

___ $40,000 - $59,999 ___$ 60,000 +

Disability:

___Mental ___Physical ___None

Preferred Language:

___English ___Spanish ___Other

Referred By:

___Dentist/Dental Group ___Doctor

___Family/Friend ___Hillcrest Employee

___Insurance Company ___Internet Search

___Phonebook ___Walk In

Advertisement

___Billboard ___Direct Mail ___Internet

___Newspaper ___Movie Theater ___Other

Responsible Party

Parent/Guardian/Guarantor:

____

Relationship: ______________________________

Address:__________________________________

____
City State Zip Code

Home Phone:______________________________

Alternate Contact Number:____________________

Dental Insurance

Insurance Company:

____

ID/Certificate #: ______________________________

Group #: __________________________________

Policy Holder: ________________________________

Relationship to Patient: __________________________

Date of Birth: _________________________________

I hereby authorize Hillcrest Dental Care, Inc. to provide my dental treatment and to furnish information to my insurance carrier concerning diagnosis and treatment. Permission is given for release of my medical information to authorized individuals pertaining to continuity of care.
I understand that I am financially responsible for any or all of my bill that is not completely paid for by my insurance carrier.

____
Signature (Patient/Guardian/Guarantor)

__________________________ __________________
Relationship Date

PATIENT INTAKE FORM

Patient Name: ____ Date of Birth: ___________________

Parent / Guardian / Guarantor Name: ____

Assignment of Benefits

______ (***initials***) I hereby authorize Hillcrest Dental Care, Inc to bill my insurance carrier and direct my carrier to make all payments directly to Hillcrest Dental Care, Inc.

Financial Obligation

Payment is required at time of service for all uninsured services.
Payment options include the following:

1. Cash or Personal Check – If a check is returned from the bank, this will result in the cancellation of all future appointments as well as a returned check fee of $30.00 on your account. Future appointments may be considered after your balance is paid in full. Personal checks will no longer be accepted.
2. Visa / MasterCard / Discover
3. Care Credit – Interest free financing may be available

Dental Insurance – We will submit to your dental insurance. Any portion that is not covered will be required at the time of service.

Finance Charges and Collection Fees- Any balance over 60 days may be subject to finance charges of 18% annually. Minimum finance charge is $5.00. The patient / guarantor is responsible for any collection or attorney fees incurred for failure to pay the balance due.

______ ***(initials)*** I have read and understand Hillcrest Dentals financial obligation.

HIPAA Privacy Authorization (Authorization for Use or Disclosure of Protected Health Information)

______ (***initials***) I authorize Hillcrest Dental Care, Inc. to use and / or disclose my protected health information to the following people.

Name	Relationship	Date of Birth (for verification only)	Phone Number

______ (***initials***) I understand that this authorization remains in effect unless terminated in writing by the patient / guardian.

____ ___________________________________

Signature (Patient/Guardian/Guarantor) Date

Hillcrest Dental Care, Inc.
Patient Notice of Privacy Practices and Policies
Effective June 23, 2015

Introduction

Hillcrest Dental Care, Inc. (HDC) is required by law to maintain the privacy of the patient's health information (PHI) and to provide individuals with notice of its legal duties and privacy practices with respect to health information. HDC is required to abide by the terms of the Notice currently in effect. HDC reserves the right to change the terms of its notice and to make the provisions of the new notice effective for all PHI that it maintains.

This Notice of Privacy Practices and Policies outlines our present practices, policies and legal duties to maintain confidentiality and to protect against prohibited disclosure of protected health information ("PHI") under the privacy regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI includes your demographic information such as your name, address, telephone number, and family; past, present, or future information about your physical or mental health or condition; and information about the medical services provided to you, including payment information, if any of that information may be used to identify you. We may maintain your PHI electronically and/or on paper.

This Notice describes uses and disclosures of PHI by HDC to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. It also advises you of your rights to access and control your PHI.

We may amend this Notice of Privacy Practices and Policies periodically. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices and Policies or you may obtain a copy by, by calling either the Pittsfield office at 413-445-6680, or the North Adams office at 413-346-4242 and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with HDC.

If you have any questions about HDC's Notice of Privacy Practices and Policies, please contact the Director of Operations at 413-445-6680.

Safeguarding PHI within our Practice

We have appropriate administrative, technical, and physical safeguards in place to protect and secure the privacy and security of your PHI. We orient our staff to the regulations and policies developed to protect the privacy of your PHI, and review their obligation to maintain privacy and security annually. We hold medical records in a secure area within our practice, and our electronic medical record system is monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only staff

members who have a legitimate "need to know" are permitted access to your medical records and other PHI. Our staff understands the legal and ethical obligation to protect your PHI and that a violation of this Notice of Privacy Practices and Policies may result in disciplinary action in accordance with our Human Resource policies.

Uses and Disclosures of PHI

As part of our registration materials, we will request your written consent for HDC to use and disclose your PHI for the following types of activities:

- **Treatment:** Treatment means the provision, coordination, or management of your health care and related services by HDC and health care providers involved in your care. It includes the coordination or management of health care by a provider with a third party insurance carrier, communication with lab or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care, or our referral of you to a specialist physician or facility.
- **Payment:** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment may also include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.
- **Health Care Operations:** Health care operations mean the legitimate business activities of HDC. These activities may include quality assessment and improvement activities; fraud & abuse compliance; business planning & development; and business management & general administrative activities. These can also include our telephoning you to remind you of appointments, or using a translation service if we need to communicate with you in person, or on the telephone, in a language other than English. When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

Electronic Exchange of PHI

We may transfer your PHI to other treating health care providers electronically. We may also transmit your information to your insurance carrier electronically.

Uses and Disclosures of PHI Based Upon Your Written Consent

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that HDC disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment, or health care operations, such as a family member or a school physical education program. If you wish us to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

Uses and Disclosures of PHI Permitted or Required by Law

In some circumstances, we may be legally bound to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to:

- **Emergencies:** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Others Involved in Your Healthcare:** Upon your verbal authorization, we may disclose to a family member, close friend or other person you designate only the PHI that directly relates to that individual's involvement in your healthcare and treatment. We may also need to use PHI to notify a family member, personal representative or someone else responsible for your care of your location and general condition.
- **Communication barriers:** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to the use or disclosure, or the physician determines that a limited disclosure is in your best interest, HDC may permit the use or disclosure.
- **Required by Law:** We may disclose your PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public Health/Regulatory Activities:** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to the appropriate regulatory agency.
- **Food and Drug Administration:** We may disclose your PHI to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, as well as to track product usage, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance.
- **Health oversight activities:** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.
- **Judicial and administrative proceedings:** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with a specific statutory obligation compelling us to do so, or with your permission.
- **Law enforcement activities:** In accordance with Massachusetts state law, we may not disclose your PHI to a law enforcement officer for law enforcement purposes without court order, statutory obligation or patient authorization.
- **Coroners, medical examiners, funeral directors and organ donation organizations:** We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person,

determining a cause of death, or other lawful duties. We also may disclose your PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.

- **Research:** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure the privacy of your PHI.
- **Serious threats to health or safety:** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military activity & national security:** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military command authorities to assure proper execution of the military mission. We may also disclose your PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation:** We may disclose your PHI as authorized to comply with worker's compensation law.
- **Inmates of a Correctional Facility:** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received your PHI in the course of providing care to you while in custody.
- **US Department of Health and Human Services:** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health & Human Services to investigate or determine our compliance with the privacy laws.
- **Disaster Relief Activities:** We may disclose your PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).

Your Rights Regarding PHI

- **Right to request restriction of uses and disclosures:** You have the right to request that we not use or disclose any part of your PHI unless it is a use or disclosure required by law. Please advise us of the specific PHI you wish restricted and the individual(s) who should not receive the restricted PHI. We are not required to agree to your restriction request, with one exception[*], but if we do agree to the request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. In that case, we will ask that the recipient not further use or disclose the restricted PHI. You may request restrictions and identify the parties to be restricted in writing to the Director of Medical Information.
- **Right of access to PHI:** You have the right to inspect and obtain a copy of your PHI upon your written request. Under very limited circumstances, we may deny access to your medical records. To request access to your medical record call HDC during business hours. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. If access is

[*] If you request that access be restricted to your PHI for services for which you have fully paid yourself out-of-pocket and not be made available to your insurance carrier, we must agree to your request.

denied, you will receive a denial letter within 30 days. There is an appeals process. We have the right to charge a reasonable fee for providing copies of your PHI.

- **Right to confidential communications:** You have the right as a reasonable accommodation to request to receive communication of PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent to an address other than your home. Please make your request in writing to HDC. We will not require an explanation of your reasons for the request, and will attempt to comply with reasonable requests, but you will be required to assume any costs associated with forwarding your PHI by alternate means.
- **Right to amend PHI:** You have the right to request that we amend your PHI. Your request must be made in writing to us. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial; HDC also has the right to submit a rebuttal statement. A record of any disagreement about the amendment will become part of your medical record and may be included in subsequent disclosures of your PHI.
- **Right to accounting of disclosures:** Subject to certain limitations, you have the right to a written accounting of disclosures of your PHI by us for not more than six years prior to the date of your request. Your right to an accounting applies to disclosures other than those for treatment, payment, or health care operations. Please make your request in writing to us. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with one accounting every 12 months, free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.
- **Right to a copy of our Notice of Privacy Practices and Policies:** We will ask you to sign a written acknowledgement of receipt of our Notice of Privacy Practices and Policies. We may periodically amend this Notice of Privacy Practices and Policies and you may obtain an updated Notice at any time.

Complaint Procedure

- **Within our Practice:** If you have a complaint about the denial of any of the specific rights listed above, about our Notice of Privacy Practices and Policies, or about our compliance with state and federal privacy law you may get more information about the complaint process by contacting HDC at 413-445-6680. We will respond to your complaint in writing within the time-frames listed above or in any case within 30 days of the date of your complaint.
- **Outside our Practice:** If you believe that HDC is not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health & Human Services, Office of Civil Rights.
- We will not retaliate against you for filing a complaint.

Hillcrest Dental Care, Inc.
Acknowledgement of Receipt of
Patient Notice of Privacy Practices and Policies

I acknowledge that I have received and understand *HDC's Notice of Privacy Practices and Policies* containing a description of the uses and disclosures of my health information. I further understand that HDC may update its *Notice of Privacy Practices and Policies* at any time and that I may receive an updated copy of *HDC's Notice of Privacy Practices and Policies* by submitting a request in writing for a current copy of *Notice of Privacy Practices and Policies.*

____
Printed Patient Name

____ __________________
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

____ ___________________
Printed Patient Personal Representative Name Relationship to Patient

____ ___________________
Patient Personal Representative Signature Date

For HDC Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

HDC made a good faith effort to obtain patient's written acknowledgment of the *Notice of Privacy Practices and Policies* but was unable to do so for the reasons described below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other____

____
Printed Employee name

____ ____________________
Employee Signature Date

Hillcrest Dental Care, Inc.
Consent for Use and Disclosure of PHI

I provide consent to HDC for use and disclosure of PHI for purposes of Treatment, Payment and Health Care operations all as defined on page 2 of the *Patient Notice of Privacy Practices and Policies.* I understand that this consent will remain in effect unless a written request is submitted to terminate this consent.

____

Printed Patient Name

____ ____________________

Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

____ ____________________

Printed Patient Personal Representative Name Relationship to Patient

____ ____________________

Patient Personal Representative Signature Date

For HDC Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

HDC made a good faith effort to obtain patient's written consent for use and disclosure of PHI but was unable to do so for the reasons described below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other____

____

Printed Employee name

____ ____________________

Employee Signature Date

Appointment Commitment Protocols

Appointment Commitment

All scheduled appointments are times reserved especially for you. Patients that consistently acknowledge and keep their scheduled appointments, or provide appropriate advance notice for any changes, are considered premier patients.

Any changes to your appointments (rescheduling or breaking your commitment) must be made two (2) business days in advance. Less than two (2) business days notice is considered a short notice broken commitment. If you short notice cancel or do not show up for your appointment, it will be considered a broken commitment.

Two (2) broken commitments within a 6 month period will result in being dismissed from our practice.

If an appointment commitment was broken due to uncontrollable circumstances, a letter may be written explaining the situation and asking for consideration of reinstatement of patient status. Patients that are granted reinstatement are required to follow our commitment agreement for 6 months. Those who fail to do this will be dismissed with no consideration for future reinstatement.

New patients who do not show up or short notice broken commitment to their first appointment will not be allowed to schedule any future appointments at our office.

Appointment Acknowledgement

As a courtesy, we offer text message, email, and phone call reminders regarding upcoming appointments. However, it is ultimately your responsibility to acknowledge and arrive to your committed appointment on time. Appointments are required to be acknowledged two (2) business days in advance to hold appointment times. Appointments that are not acknowledged two (2) business days in advance may be offered to emergency or premier patients, requiring you to wait or reschedule your appointment to a different date or time. To avoid this, simply acknowledge your appointment via text, email, or phone call two (2) business days in advance.

Premium Scheduling – Saturday Appointments and Family Scheduling

You may have an opportunity to schedule an appointment on a Saturday. For the convenience of our families, multiple family members may be scheduled as a group. These are considered premium appointments which are reserved for our premier patients. Failure to keep these premium appointment times will result in disallowing future premium appointment options.

Premium scheduling will not be available for patients that have had a broken commitment within the past 6 months.

I acknowledge that I have read, understand, and agree to the appointment commitment protocols outlined above.

Patients Name: ____________________________________ Date of Birth: ________________________

Signature: ____ Date: _______________________________