Rodney Baier, D.D.S.

INDIVIDUALIZED RESTORATIVE AND AESTHETIC DENTISTRY

Welcome to our practice

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care possible.
If you ever have any questions please do not hesitate to call us.

Patient Information

Name ______________________ Birth date ____________ SS# ______________

Address ______________________ City ______________ State _____ Zip _______

Home Phone (_____) ______________ Cell Phone (_____) ______________

E-Mail ______________________ Preferred method of contact ______________

Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Minor

Employer ______________________ Work Phone (_____) ______________

Whom may we thank for referring you to our practice? ______________________

Person to contact in case of an emergency ______________ Phone (_____) ______________

Responsible Party (If different from patient)

Person responsible for account ______________________ Relation to patient ______________

Address ______________________ City ______________ State _____ Zip _______

Birth date ______________________ SS# ______________________

Employer ______________________ Work Phone (_____) ______________

POS Proof

Insurance Information (Complete if card is not present)

Subscriber Name ______________________ Birth date ____________ SS# ______________

Insurance Company ______________ Group # __________ ID# (if different from SS#) __________

Claims Address ______________________ City ______________ State _____ Zip _______

Why have you made this dental appointment? ______________________

Was your previous dental experience a positive one? ______________________

Obstacles I see to having excellent dental care for myself...
If you select more than one of the following please number them in order of significance with #1 being that which is most significant for you at this time.

_____ **I see no obstacles**

_____ **Fear of pain, surgery, or injections**

_____ **The cost of treatment**

_____ **Time away from work or other obligations**

_____ **Fear because of past dental experiences**

_____ **Other** ______________________

OVER ➥

(Confidential)

Dental History

Do you have any specific concerns today? ______

Previous Dentist ______ Date of last cleaning ______ Date of last X-rays ______

Please mark "Yes" or "No" to indicate if you have had any of the following:

Loose teeth or broken fillings	☐ yes	☐ no	Food Collection between teeth	☐ yes	☐ no	Sensitivity biting	☐ yes	☐ no
Grinding teeth	☐ yes	☐ no	Chew on one side of mouth	☐ yes	☐ no	Periodontal treatment-history	☐ yes	☐ no
Bleeding gums	☐ yes	☐ no	Smoking/Tobacco	☐ yes	☐ no	Sensitivity to heat	☐ yes	☐ no
Clicking or popping jaw	☐ yes	☐ no	Mouth breathing	☐ yes	☐ no	Orthodontics-history	☐ yes	☐ no
Sensitivity to sweets	☐ yes	☐ no	Shortness of breath	☐ yes	☐ no	Sores/growth in mouth	☐ yes	☐ no
Sensitivity to cold	☐ yes	☐ no	Pain around ear/neck	☐ yes	☐ no	Gums swollen/tender	☐ yes	☐ no
Jaw pain or tenderness	☐ yes	☐ no	Dry mouth	☐ yes	☐ no	Mouth pain, brushing	☐ yes	☐ no
						Bad breath	☐ yes	☐ no

How often do you floss? ______ How often do you brush? ______

Are there any other methods you use to clean your mouth? ______

Is there anything you would like to change about your teeth/smile? ______

Medical History

Physician's Name ______ Date of last visit ______

Have you ever had any serious illnesses or operations within the past 5 years? ☐ yes ☐ no Describe: ______

Have you had an orthopedic total joint (hip, knee, elbow) replacement? ☐ yes ☐ no Date of replacement: ______

Any complications? ______

(Women) Are you pregnant? ☐ yes ☐ no Are you nursing? ☐ yes ☐ no Are you taking Birth Control? ☐ yes ☐ no

Check if you have any of the following:

☐ Mitral Valve Prolapse	☐ Congenital Heart Disease	☐ GE Reflux/Persistent Heartburn	☐ Ineffective Endocarditis
☐ Arthritis, Rheumatism	☐ Cortisone Treatment	☐ Hepatitis	☐ Heart Murmur
☐ Cough, Persistent	☐ High Blood Pressure	☐ Cardiovascular Disease	☐ Diabetes I or II
☐ HIV/AIDS	☐ Stroke	☐ Asthma	☐ Liver Disease
☐ Epilepsy	☐ Heart Attack	☐ Fainting	☐ Circulatory Problems
☐ Rheumatic Fever	☐ Kidney Disease	☐ Venereal Disease	☐ Cancer/Chemo/Radiation
☐ Blood Disease	☐ Back Problems	☐ Respiratory Disease	☐ Chemical Dependency
☐ Chronic Headaches/Pain	☐ Anemia	☐ Tuberculosis	☐ Hemophilia
☐ Glaucoma	☐ Pacemaker	☐ Sinus Trouble	☐ Sleep Apnea
☐ Artificial (Prosthetic) Heart Valve	☐ Thyroid Problem	LATEX Allergy: ☐ yes ☐ no	
☐ OTHER: ______		☐ Blood Transfusion/If Yes, Date ______	

List any medications you are currently taking: ______

List medications you are allergic to: ______

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that *it is my responsibility to inform my doctor if I, or my minor child, ever change in health.*

I also, hereby authorize and request the performance of dental services for myself or minor child. I also give my consent to any advisable and necessary dental procedures, medications, and anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment.

I understand that all services are charged directly to me the patient (or responsible party for minor child) and that I am personally responsible for payment of all dental services at the time services are rendered.

Patient / Guardian Signature ______ Date ______

POS Proof

FINANCIAL INFORMATION AND POLICIES
Office of Rodney Baier, DDS

General Care

You are the most important factor regarding your dental health. *Treatment* is determined by *your individual needs, not your insurance benefits.* Fees are based on the service we provide, not on insurance benefit payments. After consulting with Dr. Baier, you will ultimately decide the best course of treatment. Payment in full is due at the time services are rendered unless alternative arrangements have been made **in advance**. For your convenience, we accept Cash, Check, Amex, Discover, MasterCard and Visa. There is a $50 fee for all returned checks. This fee covers the processing fees that are charged to our office.

Insurance Benefits

We are happy to submit your claims and assist you in receiving reimbursement. To speed processing, please provide us with complete and accurate information prior to treatment. Dr. Baier is out of network, so your insurance will pay the out of network fee benefit of your plan.

We will accept estimated benefit directly from your insurance carrier. *Keep in mind that estimates given by the carrier are informational only and are not a guarantee of payment. If your carrier does not pay within 30 days after the date of service or does not pay the full estimated co-payment, you are responsible for the balance.* Regardless of insurance coverage, you are ultimately responsible for your account balance.

In order to restore you to optimal dental health, we offer several convenient payment methods from which to choose. These methods are listed below. Our Office Manager is available to discuss financial arrangements and select the method of payment that best meets your needs.

Cancellation Policy

Our office requires a 48 business hour notice of cancellation of any appointments. If you have to cancel an appointment inside of 48 business hours you will be responsible for a cancellation fee. This fee could be the full amount of the schedule appointment. If you have numerous cancellations the office will require pre-payment for your appointment.

Payment Methods

We accept payment by Cash, Check, Amex, Discover, MasterCard and Visa. Online Payments made on our website. Click on Make A Payment button.

If at any time you ever have questions, we are more than happy to help you. Please feel free to contact us.

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Patient Signature   Date

Medical Quarters
5555 Peachtree Dunwoody Rd. * Suite 340 * Atlanta Georgia 30342 * Tel 404-851-9711* Fax 404-851-9959
www.rodneybaier.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CERTAIN HEALTH INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, MAY BE USED, 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 ("PHI"), and as such we adhere to both the HIPAA and HITECH Compliance Laws passed by the US Congress and controlled by the US Department of Health and Human Services (HHS). 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, as Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This Notice takes effect April 14, 2003, and will remain in effect until we replace, edit, or update it (note that updates are made when necessary or required by law).

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted or caused 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may disclose your health information to other dental office, dentist, physician offices, laboratories, providers, agencies, facilities, pharmacies, transport companies, family members, or other health care providers and their staff involved in providing health related treatment, and services or care to you. For example: we may disclose your health information to a pharmacy to write a prescription for you. We may communicate with you about or recommend possible treatment options or alternative that may be of interest to you. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, letters, texts, emails) or informational or promotional material such as a practice newsletter.

Payment: We may use and disclose your health information (e.g. x-rays, billing statements, etc.) to persons or entities (e.g. insurance companies, family members, third party payers, health plans) so that you (or we as the case may be) can be reimbursed for treatment and services we provide you. These may be sent electronically or through other appropriate methods in order 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 educational or training programs, accreditation, certification, licensing or credentialing activities. Or to detect or prevent health care fraud and abuse. Contractual obligations, patients' claims, grievances or lawsuits, health care contracting, legal, tax, or business planning and development, business management, and administration, promotional programs, the sale of all or part of ACCD to another entity, underwriting, claims management, and other insurance activities. We may disclose your health information to another health care provider or organization to support some of their health care operations.

Relatives, Caregivers, and Personal Representatives: We may disclose your health information to a family member, friend, personal representative, or other person you identify that is involved in your dental or health care or with payment for your dental or health care. Unless you have otherwise provided us the authorization to do so, before we disclose your health information to such people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgement of whether the disclosure would be in your best interest. We may use our professional judgement 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. We may use or disclose information about you to notify or assist a person involved in your care, or your location and general condition.

Health-Related Benefits and Services: We will not sell or use your health information for marketing or fundraising purposes without your written authorization. We may contact you about benefits or services we provide.

Disaster Relief Efforts: We may use or disclose your health information to a public or private entity authorize by law or by its charter to assist in disaster relief efforts.

As Authorized or Required by Law: We will disclose health information when authorized or required to do so by applicable law, including without limitation , in response to court and administrative orders and other lawful processes; to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious

deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person; to correctional institutions regarding inmates; and as authorized by state workers' compensation laws.

News Gathering Activities: We may contact you or one of your family members to discuss whether or not you want to participate in a media or news story (e.g. a news reporter working on a story about dental health may ask whether any patients undergoing some sort of specific dental treatment may be willing to be interviewed).

National Security: As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit, including without limitation, for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury; to report adult abuse, neglect, or domestic violence; to health oversight agencies; to coroners, medical examiners, and funeral directors. To an organ procurement organization, to avert a serious threat to health or safety, in connection with certain research activities.

Lawsuits and Similar Proceedings: In connection with lawsuit or other legal proceedings, we may disclose health information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process. We may disclose health information to courts, attorneys, and court employees in the course of litigation, arbitration, or other judicial or administrative proceedings.

Law Enforcement: If asked to do so by law enforcement, and as authorized or required by law, we may release medical information : to identify or locate a suspect, fugitive, material witness, or missing person; about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death suspected to be the result of criminal conduct; about criminal conduct at ACCD; and in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

PATIENT RIGHTS

Your health information that we have created and maintain is the property of Rodney Baier, DDS. You have the following rights, however, regarding your health information that we maintain.

Right to Inspect and Copy: You have the right to look at or get copies of your health information, with certain exceptions. You may make reasonable request that we provide copies in a format other than photocopies. We will use the format you request unless it is unduly burdensome to do so. You must make a request in writing to obtain access to your health information by sending a letter to the office identified at the bottom of this notice.

Disclosure Accounting: you have the right to request a list of certain disclosures we have made of your health information. To request this accounting of disclosures, you must submit your request in writing to the office identified at the bottom of this notice. Your request must state a time period longer than the previous six years and may not include dates before April 14, 2003. That list will not include disclosures for treatment, payment, health care operations, as otherwise authorized by you, and for certain other activities.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment or healthcare operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). In your request, you must tell us: 1) what information you want us to limit, 2) whether you want to limit our use, disclosure or both, and 3) to whom you want the limits to apply. We are not required to agree to your request. If we do agree, our agreement must be in writing and signed bya person authorize to make such agreements on our behalf and we will endeavor to comply unless the information is needed to provide emergency treatment.

Right to 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, if you believe that the health information that we have about you is incorrect or incomplete. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances (e.g. it is not in writing, does not have support for the request, asks that we amend information that is inaccurate or incomplete, was not created by the office of Rodney Baier, DDS.

Rights to Copies of this Notice: You may request a paper copy of our notice. 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.

Right to File a Complaint: You may contact the Privacy Officer listed at the bottom of this notice if you believe that we have violated your privacy rights, we made a decision about access to your health information incorrectly, our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or

we should communicate with you by alternative means or at alternative locations. You 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 will not penalize you on the basis of filing a complaint. 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of Dr. Rodney Baier's office Notice of Privacy Practices.

☐ **Check box if you do not want any of your dental/medical information disclosed to anyone but you.**

If you have a caretaker, spouse, or parent that you would like Dr. Baier's to disclose information on your care with please list below.

____

____

____

____

(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
- ◻ Communication barriers prohibited obtaining the acknowledgement
- ◻ An emergency situation prevented us from obtaining acknowledgement
- ◻ Other

____