Welcome to Q Dental! Thank you for joining us in caring for your dental health. By becoming a Q patient, you have created a partnership that we hope will last through the years. We are proud to offer convenient and affordable access to comprehensive dental care.

Our partnership is prevention oriented and dedicated to your health. We are committed to providing quality care and are dedicated to our patients. Our goal is to help you look and feel your best while focusing on long-term dental health.

We invite you to view us online at www.qdental.com. Our website offers important information about our practice, locations and hours. Our new patient paperwork is also available online to help save you time at your first appointment.

Please understand that in order for any dental treatment to be rendered to a minor under the age of 18, a parent or legal guardian must accompany the minor at their visit and available to discuss necessary treatment with the dentist or hygienist.

We welcome new patients and appreciate any referrals we may earn. Our practice again welcomes you and looks forward to a long and healthy partnership with you, your family, and friends.

We value a healthy smile!

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present, or future physical or mental health condition and related health care services. This information is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. As required by The Health Insurance Portability & Accountability Act (HIPAA), we maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI. State law may provide additional restrictions on the use and disclosure of certain information such as HIV/AIDS-related information. We reserve the right to change our privacy practices and to make the new changes effective for all protected health information we maintain. Should our privacy practices change, we will post the revised Notice at our office. You may request a copy of the revised Notice at any time by contacting our Privacy Officer. We will also post the revised Notice on our website at www.qdental.com. This Privacy Notice is effective August 1, 2014.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. **Example:** *If another dentist referred you to us, we may contact that dentist to discuss your care. Likewise, if we refer you to another dentist we may contact that dentist to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for your care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, discount program, or reimbursement plan, you may restrict the disclosure of your PHI for payment. **Example:** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, you PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging other business activities. We may also disclose PHI in the course of providing you with appointment reminder or leaving messages on your phone or at your home about questions you asked or test results. **Example:** *Internal quality assessment review.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosure to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations,
- required by Court Order,
- pursuant to relevant laws and regulations, we may disclose your health information for law enforcement purposes as required or authorized by law, to report criminal activity, or in response to a valid subpoena, court order, warrant, summons, or other similar process,
- necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked except to the extent that we have relied upon it. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer.

- **Right of Access to Inspect and Copy:** You have the right, which may be restricted only in certain circumstances, to inspect and copy PHI that may be used to make decisions about services provided.
- **Right to Amend:** If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures:** You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12 month period.
- **Right to Request Restriction:** You have the right to request a restriction or limitation on the use of disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request, except as set forth above related to disclosures to a payer where you are paying in full by other means.
- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about PHI matters in a specified manner (e.g. telephone, email, postal mail, etc.)
- **Right to a copy of the Notice:** You have the right to a copy of this notice.
- **Abide by the terms of any Notice in effect.**

Website Privacy

Any personal information you provide us with via our website, including your email address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. We will have a business associate agreement with those third parties where they also agree to protect your information.

Breaches

You will be notified immediately if we receive information that there has been a breach involving your unsecured PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Q Dental. If you have any questions or would like additional information, you may contact us at Q Dental Group PC, 2300 Buffalo Road, Suite 300, Rochester, NY 14624 or with the Office of Civil Rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza – Suite 3312, New York, NY 10278, Voice Phone (800) 368-1019, Fax (212) 264-3039, TDD (800) 537-7697. There will be no retaliation for filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly,
- obtain payment from third-party payers,
- conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, except as set forth in the more detailed Notice, but if you do agree then you are bound to abide by such restrictions.

Parent/ Guardian Name: _____

Patient(s) Name: _____

Signature of Patient (Parent/Legal Guardian): _____ Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but patient refused to sign:

Reason of Refusal: _____

_____ _____

Print Patient Name Date

_____ _____

Print Employee Name Employee Signature

Financial Arrangements and Dental Benefit Plans

We are committed to providing you with the best possible care. We never want finances to stand in the way of your overall dental health; therefore, we have many different payment options. If you have a dental benefit plan, we are anxious to help you receive your maximum allowable benefits but will never base your dental needs or our recommendations on what your benefit plan is willing to cover.

In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment or co-payment is due at the time services are rendered. We accept cash, checks, and most major credit cards. We also offer convenient financing through Wells Fargo should you need to explore other options. We will be happy to process your insurance claims for both your primary and secondary plans providing we have all the information in order to do so.

We will gladly discuss your proposed treatment and answer any questions you may have. You must realize however; that:

1. We will be happy to work with your insurance company to obtain maximum benefits. We recommend you arrive at treatment decisions based on what is best for your overall dental health, not solely on what your benefit plan is willing to cover. Remaining balances not covered by your benefit plan are your FULL responsibility.

2. Because insurance policies vary greatly, we can only ESTIMATE your coverage in good faith but cannot guarantee coverage due to the hundreds of companies we deal with and the complexities of insurance contracts. If you would like to know your exact insurance benefit, we encourage you to reach out to your insurance plan and/or we will be happy to send a pre-determination of benefits to your insurance company upon your request. Please note that obtaining a predetermination from your insurance company will delay any procedure until after we hear back from the insurance company.

3. While the filing of insurance claims is a service that we provide to our patients, all charges remain your responsibility from the day services are rendered.

We must emphasize that as dental care providers our relationship is with you. If you need to discuss other payment options, we encourage you to contact us promptly for assistance in the management of your account.

We will require full payment or co-payment for services rendered, as well as payment for any outstanding balance on your account. For any extensive procedures, we will ask that you discuss financial options prior to the day of service. Please let us know if arrangements need to be made before you come in for your appointment. There will be a finance charge of 1.5% monthly on any balances over 90 days old. In the event that it becomes necessary for Q Dental to pursue legal actions to collect financial obligations for services rendered, you will be responsible for all collection and/or attorney fees.

For those who need long term financing, we are excited to tell you about Wells Fargo. This card works like a credit card and can be used for both your services as well as your families. It is revolving, so that you can continue to use it for services down the road. You can apply online at www.wellsfargohealthadvantage.com/apply or our Patient Care Coordinators will be happy to assist you with the application process while you are in the office.

Regarding appointments, please realize that a specific amount of time is reserved especially for you. If you must change your appointment, we will require at least 24 hours notice to avoid $35 cancellation fee.

Our Patient Care Coordinators will be happy to assist you with any questions you may have. We look forward to seeing you at your next visit.

I have read, understand, and agree to adhere to the above stated policy.

_____	_____	_____
Patient or Responsible Party Signature	Print Name	Date

Patient Information Sheet

Today's Date				
Patient Name				
Address		City	State	ZIP
Home Phone	Cell Phone	E-mail Address		
Employer				
Address		Work Phone		
Parent/Spouse Name		Date of Birth	SS#	
Physician		Phone #		
Pharmacy Name				
Address		Phone #		
If minor, name of person responsible for healthcare decisions:				

Responsible Party

Name of person responsible for payment on this account:				
Date of Birth	SS#	Relationship to Patient		
Address		City	State	ZIP
Home Phone	Cell Phone	Business Phone	E-mail Address	
Employer Name		Address	Phone #	

Primary Insurance Information

Name of Insured			SS#	
Relationship to Patient		Date of Birth		
Name of Employer		Insurance Co		
Address		Address		
Phone		Claims Address:		
Group #	Plan/Union #	Subscriber ID#		

Secondary Insurance Information

Name of Insured			SS#	
Relationship to Patient			Date of Birth	
Name of Employer		Insurance Co		
Address		Address		
Phone		Claims Address:		
Group #	Plan/Union #	Subscriber ID#		

_____ I understand that I am responsible for notifying the office if this information changes at any time.

_____ I understand that all charges not covered by my insurance plan remain my full responsibility from the time services are rendered.

Signature of patient (or parent/guardian of minor)_____ Date_____

Health History

Patients Name					Date of Birth	Date	
Name of Physician					List any Specialist(s) you are seeing		
		Y	N			Y	N
1	Are you under medical treatment now?			8	Do you smoke or chew Tobacco?		
					How much per day		
2	Have you ever been hospitalized for any			9	DO YOU HAVE OR HAVE YOU EVER HAD		
	surgical operation or serious illness within the				Rheumatic Fever		
	last 5 years?				Congenital Heart Disease		
	If yes, please explain				Cardiovascular Disease		
					Heart Attack		
					Heart Murmur/ Mitral Valve Prolapse		
3	Are you taking any medication(s) including				Coronary Artery Disease		
	non-prescription medicine? If yes, please list				Angina		
					High Blood Pressure		
					Low Blood Pressure		
					Heart Surgery		
4	ARE YOU USING ANY OF THE FOLLOWING:				Pacemaker		
	Antibiotics				Stroke		
	Anticoagulants (Blood Thinners)				Lung Disease		
	Aspirin or drugs such as Motrin, Aleve, Ibuprofen				Asthma		
	High Blood Pressure medications				Emphysema		
	Steroids				Bronchitis		
	Tranquilizers				Pneumonia		
	Insulin or Oral Anti-Diabetic Drugs				Tuberculosis		
	Digitalis				Severe or Chronic Cough		
	Inderal				Seizures/ Convulsions		
	Nitroglycerin				Epilepsy		
					Fainting or Dizziness		
5	HAVE YOU EVER TAKEN BISPHOSPHONATES				Bleeding Disorders		
	Fosamax, Boniva, Aredia, Bondronat, Zometa,				Anemia		
	Chemotherapy for Multiple Myeloma, or				Blood Transfusion		
	Actonel for osteoporosis				Liver Disease		
6	ARE YOU ALLERGIC OR HAVE YOU HAD AN				Thyroid Disease		
	ADVERSE REACTION TO:				Arthritis		
	Local Anesthesia (Novocain, etc)				Glaucoma		
	Penicillin or other antibiotics				Cancer		
	Sedatives, Barbiturates				Radiation Therapy		
	Aspirin or Ibuprofen				Leukemia		
	Codeine or other pain killers				Sexually Transmitted Disease		
	Latex or Rubber Products				AIDS or HIV infection		
	Other allergies or reactions? Please List				Implants placed in any area (hip, heart, knee, etc)		
					Any disease, drug that depresses immune system		
				10	Women Only:		
7	Is there any history of Alcohol or Chemical				Are you pregnant or think you may be pregnant?		
	Dependency or Emotional Disorder that may affect the care we provide you?				Are you nursing?		
					Are you taking oral contraceptives?		

Dental History

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. Please fill out this form completely to help us meet all your dental needs. If you have any questions, please ask us, we will be happy to help.

Name of Previous Dentist Location

What prompted you to leave that practice?

		Y	N
1	Do your gums bleed while brushing or flossing?		
2	Are your teeth sensitive to hot or cold liquids/foods?		
3	Are your teeth sensitive to sweet or sour liquids/foods?		
4	Do you feel pain to any of your teeth?		
	If yes, please explain		
5	Do you have any sores or lumps in or near your mouth?		
6	Have you had any head, neck or jaw injuries?		
7	Have you ever experienced any of the following		
	Clicking of your jaw		
	Pain (jaw joint, ear, side of face)		
	Difficulty in opening or closing		
	Difficulty in chewing		
9	Do you clench or grind your teeth?		
10	Do you bite your lips or cheeks frequently?		
11	Have you ever had any prolonged bleeding after extractions?		
12	Have you had any orthodontic treatment?		
13	Do you have or have you ever had Oral Cancer?		
14	Do you wear dentures or partials?		
15	Do you like your SMILE?		
16	What would you like to change about your smile?		
17	Date of Last exam with Previous Dentist		
18	Date of Last Dental X-rays		
19	Have you ever been told that you need to pre-medicate for dental work?		

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentists to release any information including my diagnosis and any records to facilitate in my or my child's dental care and/or receive reimbursement for any and all services provided.

Signature of Patient (or parent/guardian if minor) Date