

Kirkland Endodontics

Boyd F. Munson, DMD, PS
Tom J. Rude, DDS, PS



Patient Confidential Information

First Name _____ MI _____ Last Name _____ Nickname _____

* If Patient is a minor,
Responsible party _____ Relationship _____ Contact # _____

Billing Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Employer _____ Occupation _____

Patient's Birth date Month _____ Day _____ Year _____

Check Appropriate Box: Minor Single Married Divorced Widowed

Spouse _____ Employer _____ Occupation _____

Emergency Contact Name _____ Phone _____

Referring Dentist _____ How long have you been their patient? _____

Your Estimated Portion is Due Upon Completion of Services

How would you like to pay for today's visit? _____ (Cash, Credit Card etc...)

You Are Financially Responsible for Any Services at This Office

As a courtesy to our patients we are happy to file your Insurance Claim. PLEASE REMEMBER THAT THE INSURANCE CONTRACT IS BETWEEN YOU AND YOUR INSURANCE CARRIER. Assignment & Release: I authorize the dentist or insurance company to release information required for payment or review of this treatment. I authorize payment of benefits, otherwise payable to me to be paid directly to the dentist.

Signature of patient (or guardian) _____ Date _____

Insurance Information

Primary Dental Insurance _____ Group _____

Name of Insured _____ Relationship to Patient _____

Insured's Birth Date: Month _____ Day _____ Year _____ SS# or Id# _____

Insured's Employer _____ Ins. Co Phone _____

Ins. Co. Address _____ City _____ St _____ Zip _____

Secondary Insurance Information

Secondary Dental Insurance _____ Group _____

Name of Insured _____ Relationship to Patient _____

Insured's Birth Date: Month _____ Day _____ Year _____ SS# or Id# _____

Insured's Employer _____ Ins. Co Phone _____

Ins. Co. Address _____ City _____ St _____ Zip _____

Health History Form



First Name:

MI:

Last Name:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p>Are you now under the care of a physician? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Physician Name: _____ Phone: <i>Include area code</i> ()</p> <p>Has there been any change in your general health within the past year?.. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what condition is being treated? _____</p>	<p>Have you had a serious illness, operation or been hospitalized in the past 5 years?..... Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what was the illness or problem? _____</p> <p>Date of last physical exam: _____</p>
<p>Are you taking or have you recently (last 12 months) taken any prescriptions or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:</p> <p>_____</p> <p>_____</p>	

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p><i>(Check DK if you Don't Know the answer to the question)</i> Yes No DK</p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Name of physician or dentist making recommendation: _____</p> <p>Phone: <i>Include area code</i> ()</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax[®], Actonel[®], Atelvia, Boniva[®], Reclast, Prolia) for osteoporosis or Paget's disease?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia[®], Zometa[®], XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p>Do you use tobacco (smoke/chew)? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use marijuana? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Alcohol or Drug abuse? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>How much alcohol did you drink in the last 24 hours? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. Yes No DK</p> <p>Local anesthetics (novocaine) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin, acetaminophen, ibuprofen _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics, hydrocodone, oxycodone _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Metals _____ Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (or rubber dam) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Health History Form - Page 2

First Name: _____ MI: _____ Last Name: _____

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

			Yes	No	DK				Yes	No	DK				Yes	No	DK																																																																																																																																						
Artificial (prosthetic) heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous infective endocarditis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damaged valves in transplanted heart.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease (CHD)				Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unrepaired, cyanotic CHD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repaired (completely) in last 6 months.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify:_____				Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____				Cancer/Chemotherapy/ Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection: _____				Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/ migraines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

			Yes	No	DK				Yes	No	DK																																																																				
Cardiovascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date:_____				Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

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 and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

HIPAA

Statement of Privacy Practices



This statement of privacy practices describes how dental information about you may be disclosed and how you can get access to this information. Please read carefully

Our practice collects and maintains a record of the health care services we provide you. In keeping with the Health Insurance Portability and Accountability Act (HIPAA), and current state regulations we are dedicated to protect your rights of privacy and the confidential information entrusted to us.

The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We will not disclose your protected health information unless you direct or authorize us to do so or unless it is otherwise allowed or compelled by law. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

You may see your record or get more information about it at “Your Individual Rights about Patient Health Information” section of the Notice. You may request to review and copy your personal record and you may also request that we make corrections to the record.

OVERVIEW

Our Statement of Privacy Practices is currently in effect and provides information about the use and disclosure of protected health information by our practice and our employees. It is applicable in all instances wherein individually identifiable health information is collected from you and services are provided for you. Our Statement:

1. Defines your rights and our obligations when using your health Information,
2. Informs you about laws that provide special protections,
3. Explains how your protected health information is used and how, under certain circumstances, it may be disclosed,
4. Tells you how changes in this statement will be made available to you.

In synopsis form, you have a right to:

1. Request restricted use of your health information. (Please understand that we may not agree to your request),
2. Request that we not disclose to your health plan of services for which you self-pay in full,
3. Request that we communicate with you by alternate methods,
4. Review and receive copies of your personal health record,
5. Request for amendments and/or changes be made to your record,
6. Request an accounting of disclosures of your health information,
7. File complaints related to failure to protect the privacy of your health information,
8. Direct us not to share information with your family members,
9. Request that you not be listed in/on our facility directory,
10. Be informed that some regulations, such as those addressed under Substance Use Disorder rules are more restrictive than HIPAA rules.

HIPAA

Statement of Privacy Practices



PROTECTED HEALTHCARE INFORMATION (PHI)

It is important that you know not only that we limit requests for your personal information to that needed to provide quality health care, implement payment activities, and conduct normal health practice operations, but understand what “Protected Healthcare Information” is. This may include your name, address, telephone number(s), Social Security Number, employment data, dental history, health records, and/or any personal information that is unique to you.

While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the HIPAA and the state regulations. This includes when it is used and disclosed to perform treatment, obtain payment, and conduct operational activities. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our Statement of Privacy Practices applies to all personal health information collected or created by our employees or received from outside healthcare providers. This information may identify you, relate to your past, present or future physical or mental condition, the care provided, or any reference to payment for your health care.

For example, protected health information includes symptoms, test results, diagnoses, health information from other providers, as well as billing and payment information relating to these services. This information is protected because it is often part of your health or dental record, which we can use as:

1. A method of communication among health professionals who contribute to your care,
2. A legal record describing the care you received,
3. A means by which you can verify that services billed were provided,
4. A tool to educate health professionals,
5. A source of data for dental research,
6. A source of information for public health officials,
7. A source of information for facility planning,
8. A tool to assess and improve the care we provide,
9. A method by which we can provide a better understanding of your record,
10. A method by which we can ensure your record’s accuracy,
11. A system to assist you to more clearly understand the circumstances and conditions in and by which others may have access to your personal information.
12. A tool for us to make more informed decisions when authorizing disclosures to others.

HIPAA

Statement of Privacy Practices



PHI USE AND DISCLOSURE- WITHOUT YOUR AUTHORIZATION

As stated above we may, under allowed circumstances use and disclose protected health information (PHI) without your specific authorization. Examples of such instances are included below:

Treatment: We may use and disclose your PHI to provide treatment. For example, we can:

1. Use your information to find out whether certain tests, therapies, and medicines should be ordered,
2. Provide your information to staff members to better understand what your healthcare needs are how to evaluate your response to treatment,
3. Disclose your PHI to another one of your treatment providers in order to provide you with the best possible health care.
4. Share, with your consent and authorization, PHI relating to substance use disorder with substance disorder treatment programs, doctor's offices, and health care businesses for those activities

Payment: We may use your health information for payment purposes. Such instances may include:

1. Preparation of claims for payment of services,
2. Billing your insurance directly, including information that identifies you, as well as your diagnosis, the procedures performed, and supplies used so that we can be paid for the treatment provided,
3. Collection activities (if necessary) to obtain payment for services.

Health Care Operations: We may use and disclose your health information to support the daily activities related to health care. Examples include:

1. Use and disclosure to monitor and improve our health services.
2. Use by authorized staff to review at portions of your record to perform administrative activities.

Train Staff and Students: We may use and disclose your information to teach and train staff how to review patient health information.

Contact You for Information: Your PHI may also be used to contact you. In example, we may call you or send you a letter to remind you about your appointment, provide test results, inform you about treatment options, or advise you about other health-related benefits and services.

Business Associates. Your PHI may be used and disclosed as needed to individuals, organizations, or companies to comply with our legal obligations described in this Notice. An example is disclosure of your PHI to consultants, attorneys, or third parties to assist in our business activities. All such entities must sign a Business Associate Agreement to protect the confidentiality of your private information.

ADDITIONAL USES AND DISCLOSURES

We also use and disclose your information to enhance health care services, protect patient safety, safeguard public health, ensure that our facilities and staff comply with government and accreditation standards, and when otherwise compelled or allowed by law not in conflict with exceptions established under HIPAA's Substance Use Disorder requirements. For example, we may provide or disclose information:

1. About FDA-regulated drugs and devices to the U.S. Food and Drug Administration.

HIPAA

Statement of Privacy Practices



2. To government oversight agencies with data for health oversight activities such as auditing or licensure.
3. To public health authorities with information on communicable diseases and vital records.
4. To your employer, findings relating to the evaluation of work-related illnesses or injuries.
5. To workers' compensation agencies and self-insured employers for work-related illness or injuries.
6. To appropriate government agencies when we suspect abuse or neglect.
7. To appropriate agencies or persons when we believe it necessary to avoid a serious threat to health or safety or to prevent serious harm.
8. To organ procurement organizations to coordinate organ donation activities.
9. To law enforcement when required or allowed by law, including the Office of Civil Rights to conduct OCR investigations.
10. For court order or lawful subpoena (see note below).
11. To coroners, medical examiners, and funeral directors.
12. To government officials when required for specifically identified functions such as national security.
13. When otherwise required by law, such as to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with our obligations to protect the privacy of your health information.
14. If you are a member of the armed forces, we may release dental information about you as required by military command authorities. We may also release dental information about foreign military personnel to the appropriate foreign military authority.

NOTE: If PHI is disclosed pursuant to the HIPAA Privacy Rules' Substance Use Disorder allowances and requirements, the records could potentially be redisclosed and will no longer be protected under the HIPAA Privacy Rule.

YOUR RIGHTS TO OBJECT

Disclosure to Family, Friends, or Others. You may object to our disclosing your general health condition ("good", "fair", "critical", etc.) to an individual, or individuals, you have identified who have an active interest in your care, payment for your health care, or who may need to notify others about your general condition, location, or death. If you do not so indicate, we will use our best professional judgment to provide relevant protected health information to your family member, friend, or another identified person.

USE AND DISCLOSURES REQUIRING AUTHORIZATION

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. You may revoke your written authorization, at any time unless prohibited by law, or disclosure is required for us to obtain payment for services already provided, or we have otherwise relied on the authorization.

HIPAA

Statement of Privacy Practices



Your PHI will not be released for use in legal proceedings against you unless (a) you consent or otherwise authorize its release or the release is based on a Part 2 court order and a subpoena, or similar legal requirement.

ADDITIONAL PROTECTION

Special state and federal laws apply to certain classes of patient health information. For example, additional protections may apply to information about sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records, and HIV/AIDS information. When required by law, we will obtain your authorization before releasing this type of information.

YOUR INDIVIDUAL RIGHTS

You may contact us to exercise your rights related to the use and disclosure of your protected health information.

Your specific rights are listed below and include:

1. **The right to request restricted use:** You may request in writing that we not use or disclose your information for treatment, payment, and/or operational activities except when authorized by you, when required by law, or in emergency circumstances. We are not legally required to agree to your request. If you request that we restrict the use of your private information, we will provide you with written notice of our decision about your request.
2. **The right to request non-disclosure to health plans:** You have the right to request in writing that health care items or services for which you self-pay for in full in advance of your visit not be disclosed to your health plan.
3. **The right to receive confidential communications:** You have the right to request that we communicate with you about dental matters in a particular way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the address above. We will grant all reasonable requests. Your request must specify how or where you wish to be contacted.
4. **The right to inspect and receive copies:** In most cases, you have the right to inspect and receive a copy of certain health care information including certain dental and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
5. **The right to request an amendment to your record:** If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that we make a correction or add information. In your request for the amendment, you must give a reason for the amendment. We are not required to agree to the amendment of your record, but a copy of your request will be added to your record.
6. **The right to know about disclosures:** You have the right to receive a list of instances in which we have disclosed your health information. Certain instances will not appear on the list, such as disclosures for treatment, payment, or health care operations or when you have authorized the use or disclosure. Your first accounting of disclosures in a calendar year is free of charge. Any additional request within the same calendar year requires a processing fee.
7. **The right to make complaints:** If you believe that we have violated your privacy, or you disagree with a decision we made about access to your records, you may file a complaint directly to our doctor or any member of our workforce with directions that it be relayed to our doctor in charge.

HIPAA

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You may also contact:

**U.S. Department of Health and Human Services,
Office for Civil Rights:
2201 Sixth Avenue - Mail Stop RX-11
Seattle, WA 98121-1831
206-615-2290; 206-615-2296 (TTY)
206-615-2297 (fax)
Toll free: 1-800-362-1710; 1-800-537-7697 (TTY)**

BREACH NOTIFICATION

If it is found that your patient information is used or disclosed in a manner that is not consistent with the practices described in this notice, the incident will be fully investigated to assess if there was a breach in the protection of your PHI. The assessment will be conducted to determine whether the information disclosed has significant risk of physical, financial, or reputational harm to you. If so, we will notify you and submit appropriate information to OCR and the United States Department of Health and Human Services in writing.

PRIVACY NOTICE CHANGES

We are required by law to protect the privacy of your information, to provide this Statement of Privacy Practices and to follow the privacy practices that are described herein. We reserve the right to change the privacy practices described and the right to make the revised or changed Statement effective for protected health information we already have as well as any information we may receive in the future.

We have posted a copy of our current Statement for your review and reference. Additionally, each time you visit our office for treatment or health care services, you may request a copy of our current Statement of Privacy Practices. An electronic version of the notice is posted on our web site.

Kirkland Endodontics

Boyd F. Munson, DMD, PS
Tom J. Rude, DDS, PS



Acknowledgement of Privacy Practices

11830 NE 128th St. Suite 101
Kirkland, WA 98034
(425) 821-7100
FAX (425) 820-8208
info@KirklandEndodontics.com

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ Date _____

Signature _____

Relationship to patient _____

Please list other persons with whom we may share your Protected Health Information:

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights for the following reason:

- Patient refused to sign
- Communication barriers
- Emergency situation
- Other



Financial Policy

Thank you for choosing Kirkland Endodontics for your endodontic care. Our office is committed to providing you with the best possible care. The following is a statement of our Financial Policy, which we require you to read and sign prior to receiving any treatment.

Regarding Payment

We gladly accept several forms of payment which include cash, check, MasterCard, Visa, American Express and Discover. Payment is expected at the time of treatment unless arrangements were made in advance with our Financial Coordination team. Insurance co-payments are also expected at the time of service. If returning for treatment after an exam, your entire balance will be collected at the treatment appointment.

Regarding Insurance

It is important to understand that the insurance contract is between the insurance company and you, the insured. Our office will gladly estimate and submit your insurance claim to your insurance carrier, as a courtesy to you. Due to insurance policy changes and/ or necessary changes in treatment plans, the insurance coverage may vary from the estimated treatment calculation. The patient/guarantor is responsible for the portion that insurance does not cover.

Print Name

Signature

Date