Notice of Privacy Practices

Federal & State laws require Paradise Valley Smiles to maintain the privacy of all patient healthcare information. Furthermore, we are required by law to provide all parents or legal guardians with this notice reviewing our privacy practices, our legal obligations and your rights in regard to your child's healthcare information. Paradise Valley Smiles must follow the privacy practices as described within this notice while this policy is in effect. This notice takes effect on February 1st, 2008 and will remain in effect until replaced, amended, or eliminated.

Paradise Valley Smiles reserves the right to change these privacy practices and the terms of this notice at any time provided such applicable laws permit such changes. We reserve the right to make any needed changes to our privacy practices and these new terms will be effective for all health information that we maintain, including health information we create or receive before such made changes. Before we make any significant changes to our privacy practices, we will change this notice and make new notice available upon request.

Parent or legal guardians may request a copy of this notice, at any time. For additional information about our privacy practices or to review our company's Health Insurance Portability & Accountability Act (HIPAA) Manual, please contact our office at any time.

USES & DISCLOSURES OF HEALTHCARE INFORMATION

Paradise Valley Smiles will use and disclose patient healthcare information during your treatment, while obtaining payment from insurance companies and during general healthcare operations. For example:

Treatment. Paradise Valley Smiles may use your health information during direct treatment or by disclosing such information to other dentists, physicians or healthcare providers who may provide specialized treatment for you.

Payment. We may also use and disclose your health information to obtain payment for services rendered. We may disclose your healthcare information to another healthcare provider or entity that is also subject to these same federal & state privacy rules and regulations for payment activities.

Healthcare Operations. We may use and disclose your healthcare information during our routine healthcare operations. Healthcare operations may include quality assessments and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities. We may disclose your healthcare information to another healthcare provider or organization that is subject to the same federal & state privacy rules and regulations and that has a relationship with you during the support of healthcare operations. We may disclose your information to help such organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals, or detect or prevent healthcare fraud or abuse.

On Your Authorization. You may give Paradise Valley Smiles written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any issues or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason except those described within this notice.

To Your Family & Friends. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for previously performed healthcare services. Before we disclose your health to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event you are incapacitated and cannot make a decision for yourself, or in the event of an emergency, we will disclose your medical information based on our professional judgment of practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical/dental supplies, radiographs or other similar forms including health information. We may also use or disclose information about you to notify or assist in notifying a person involved in his/her care.

Appointment Reminders. Paradise Valley Smiles may use or disclose your healthcare information to provide you and your family with appointment reminders. (Such as: telephone calls, voice messages, postcards, or letters)

Disaster Relief. We may use or disclose your healthcare information, as authorized by federal or state law for the following purposes deemed to be in the public's best interest or benefit:

- As required by law
- For public health activities, including disease and vital statistic reporting, reporting child abuse or neglect, FDA oversight and to employer's regarding work-related illness or injury.

- To health oversight agencies
- In response to court and administrative orders and lawful processes
- To law enforcement officials pursuant to subpoena 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 persons.
- To coroners, medical examiners and funeral directors
- To an organ procurement organization
- To avert serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- To correctional institutions regarding inmates
- As authorized by state worker's compensation laws

PATIENT or PARENT/LEGAL GUARDIAN RIGHTS

Access. You have the right to look at or receive a copy of your health information, with limited expectations. You may request that we provide a copy in format other than photocopies. We will use the format you request unless we cannot practically do so. You must make all requests in writing to obtain access to your child's healthcare information. You may request access by sending us a letter. If you request a copy, we will charge you a reasonable fee, which may include labor, copying costs and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may, but are not required to, prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting. You have the right to receive a list of instances in which Paradise Valley Smiles or any business associates disclosed your
health information over the past year (but not prior to June 24th 2010). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you and certain activities. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction. You have the right to request that we place additional restrictions on the use or disclosure of your healthcare information. We are not required to agree with such additional restrictions, but if we do, we will abide by our agreement (except in the event of an emergency). Any agreement we make to a request for additional restrictions must be in writing and signed by our privacy officer. Your request is not binding unless our agreement is in writing.

Alternative Communication. You have the right to request that we communicate with you about your health information by an alternative means or at an alternative location. You must make your request in writing. You must specify in your request the alternative means or location and satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment. You have the right to request that we amend your healthcare information. Your request must be in writing and should explain why you are requesting this amendment. We may deny your request under certain circumstances.

QUESTIONS OR COMPLAINTS

If you need additional information regarding our office's Privacy Practices & Regulations or have specific questions or concerns, please feel free to contact us. Furthermore, if you believe that:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly
- Our response to a previous request to amend or restrict the use or disclosure of your information was incorrect
- We should communicate with you by alternative means or an alternative location

You may submit a written complaint with our privacy officer or directly to the US Department of Health & Human Services. We will provide you with these addresses to file your complaint, upon request. We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health & Human Services.

I understand the contents of the previous notice concerning the privacy of my confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Paradise Valley Smiles from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

_____ _____

Signature of Patient/ Parent or Guardian Date

AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION FORM

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

Authorization to Speak with Family/Friend (including spouses)

I give the following named person(s) authorization to take messages or speak with the office of Paradise Valley Smiles on my behalf regarding (please check all items authorized):

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

I understand my express consent is required to release my health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed below.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Medical History

Name _____ Date _____

Are you under physician's care now? Yes No If yes, please explain _____

Have you been hospitalized or had a major operation? Yes No If yes, please explain _____

Are you taking any medications? Yes No If yes, please list _____

_____

Women: Are you
Pregnant/trying to get pregnant _____ Nursing _____
Taking contraceptives? _____

Are you allergic to any of the following?

____ Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____ Latex ____ Local Anesthetics

Other _____

Do you have, or have you had, any of the following?

_____ AIDS/HIV Positive
_____Anemia
_____Arthritis, Rheumatism
_____Artificial Heart Valves
_____Artificial Joints
_____Asthma
_____Back Problems
_____Blood Disease
_____Cancer
_____Chemical Dependency
_____Chemotherapy
_____Circulation Problems
_____Cortisone Treatments
_____Cough Persistent
_____Cough up Blood
_____Diabetes
_____Epilepsy
_____Fainting
_____Glaucoma
_____Headaches
_____Heart Murmur
_____Heart Problems
_____Hemophilia/Abnormal Bleeding
_____Herpes
_____Hepatitis
_____High Blood Pressure
_____Jaw Pain
_____Kidney Disease or Malfunction
_____Liver Disease
_____Mitral Valve Prolapse
_____Nervous Problems
_____Pacemaker/Heart Surgery
_____Psychiatric Care
_____Rapid Weight Gain or Loss
_____Radiation Treatment
_____Respiratory Disease
_____Shingles
_____Shortness of Breath
_____Skin Rash
_____Spinal Bifida
_____Stroke
_____Surgical Implant
_____Swelling of Feet/Ankles
_____Thyroid Disease
_____Tobacco Habit
_____Tuberculosis
_____Ulcer/Colitis
_____Venereal Disease

Has there been any changes in your health since your last dental appointment? Yes/No

For what conditions? _____

Are you taking any new medications? Yes/No _____

_____

_____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Dental Practice Policies

Welcome to our dental office. We appreciate the opportunity to assist you with your dental care needs. Our goal is to provide you and your family with the best dental care available at an affordable cost and in an efficient and professional manner. We can only accomplish this goal with your help. With this in mind, we have listed our office policies below for your review.

_____ **Should you be unable to make your scheduled appointment we request that you notify the office at least 24 hours in advance.** We will make every effort to confirm your appointment with you; however, it is your responsibility to keep that appointment. A broken appointment fee of **$100 Monday-Friday and $125 for Saturday** may be billed to your account if you fail to notify the office within the time frame specified.

_____ Payment is due at the time of service. We accept cash, money orders, debit cards and all major credit cards as payment. For your convenience, we accept most dental insurances. As a courtesy, we will be happy to file your dental insurance claim to your insurance company on your behalf. **Insurance claims that are not paid within 60 days become the sole responsibility of the patient. If the balance on your account becomes more than 90 days past due, your account will be transferred to a collection agency and a fee of 35% of the balance will be added to your account.**

_____ We try very hard to adhere to a schedule. If you are more than 15 minutes late, we may have to reschedule your appointment. Sometimes an emergency will occur that will make us run behind. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing our dental family and look forward to a long relationship with you.

_____ Please understand that dentistry is **not** an exact science and therefore reputable practitioners cannot properly guarantee results. No guarantee or assurance has been made by anyone regarding dental treatment that you have requested or authorized. Each dentist is an individual practitioner and is individually and solely responsible for the dental care rendered.

_____ Your original records belong to the office. You may request copies for you or others. We will provide them within five business days upon receiving a written request from you. There will be a fee to duplicate your chart.

_____ The patient and dentist (including their corporations, representatives, staff, agents, parents, guardians, children and all related individuals and entities) agree that all litigation events that occurred in the dental office will be determined through submission to an arbitrator, and NOT by a lawsuit or other legal proceeding filed in a federal, state, county or municipal court. By signing this Arbitration Agreement, the parties waive and forfeit their constitutional, statutory or common law rights for a judge or jury to decide any legal questions or disputes, and instead accept the sole use of a private arbitrator. This Arbitration Agreement covers all disputes as to dental treatment, financial matters or any other events that occurred in the dental office whether in tort (intentional or neglect), contract, statute, common law or otherwise, and including without limitation all actions relating to dental negligence, return of fees, loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. The arbitration shall bind all parties, including without limitation any spouse or heirs, and will NOT be subject to court review. Either party may initiate arbitration by serving on the other a written “Demand for Arbitration” form by certified mail. No other form of service will be acceptable. The Demand for Arbitration must identify all parties, include their contact information, describe the claims against each party, and state the amount of damages sought. Either party then may continue the proceedings by contacting the American Arbitration Association (“AAA”). A single AAA arbitrator, mutually selected by the parties, will conduct the arbitration. All proceedings will be resolved using the AAA rules. Arizona law will apply. If any provision of this Arbitration Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and effect.

Patient Signature: _____ Witness Signature: _____

Patient Print Name: _____ Witness Print Name: _____

Date: _____

Patient Information

Please Print

Title: ____ First Name: _____ Mid: _____ Last: _____

Preferred Name:_____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Social Security #_____-_____-_____ Patient Date of Birth: _____ Sex: **M** **F**

Email Address: _____ May we contact you by email? **Yes** **No**

Emergency Contact: _____ Phone: _____

How did you hear about our office? _____

*If patient is under the age of 18, Parent or Guardian please fill out below:

Parent/Guardian Name_____

Date of Birth:_____ Social Security #_____-_____-_____

Insurance Information

Do you have Dental Insurance? **Yes** **No**

Primary Insurance	**Secondary Insurance**
Subscriber Name:_____	Subscriber Name_____
Subscriber SSN: _____	Subscriber SSN: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber:	Relationship to Subscriber:
Self **Spouse** **Child** **Other**	**Self** **Spouse** **Child** **Other**
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone # _____
Insurance Company: _____	Insurance Company: _____
Insurance Group # _____	Insurance Group #_____
Insurance Phone # _____	Insurance Phone #_____
Insurance Address: _____	Insurance Address: _____

Please present insurance card and Drivers License

To better serve you, please take a minute to answer the following questions

Please check any of the following problems that apply to you:

- ○ Sensitivity (hot, cold or sweet) If so, which teeth? _____
- ○ Headaches, earaches, neck pain _____
- ○ Teeth or fillings breaking
- ○ Grinding or clenching teeth
- ○ Bleeding, swollen, or irritated gums
- ○ Loose, tipped or shifting teeth
- ○ Bad breath

Who was your previous dentist?

Name _____

Last cleaning _____ Last x-rays _____

Do you have or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) Yes/No

Have you ever had Botox/Botulinum toxin or Dermal fillers? Yes/No

If no, would you be interested in discussing improving your smile with Botox/Botulinum or Dermal Fillers? Yes/No

Do you have sleep apnea? Yes/No If yes, have you had a sleep study in the last 5 years? Yes/No _____

Have you ever worn a CPAP Yes/No

Do you snore? Yes/No Do your gums ever bleed? Yes/No

How many times a day do you brush? _____ How many times do you floss? _____

Do you like your smile? Yes/No Explain _____

_____

If you could change your smile, would you:

- ○ Make your teeth whiter
- ○ Make your teeth straighter
- ○ Close spaces between teeth
- ○ Replace silver/mercury fillings
- ○ Repair chipped teeth
- ○ Repair missing teeth
- ○ Replace old crown that don't match
- ○ Have a smile makeover
- ○ Smooth out wrinkles around my lips and mouth
- ○ Have a less 'gummy' smile

What is the most important thing to you about your dental visit today?

_____

When you think of cosmetic dentistry, you may not think about Botox/Botulinum and dermal fillers. But the truth is the appearance of your mouth and smile has a lot to do with how attractive you look and feel. Our doctors have the skill and know-how to use Botox/Botulinum and dermal fillers to enhance your lips, smooth lip lines, and eliminate wrinkles around the mouth to create a more beautiful and youthful appearance. We can offer these services during routine dental appointments in a completely painless manner with more training and knowledge in oral and oral-facial areas than any other health care professional. Let our staff know if you are interested in discussing Botox/Botulinum and dermal fillers with our doctors.