

## Insurance Information

Please be aware that your insurance policy is a contract between you and your insurance company. As a courtesy to you, we will bill your insurance for eligible charges on your behalf. It is important for you to know that you are responsible for all charges at our office including any balances that are pending payment from your insurance.

When we contact your insurance carrier to get benefits, please know that this is a general breakdown and not a guarantee of benefits. There are no pre-authorizations or pre-determinations given by your insurance company to us at that time. Any pre-authorizations or pre-determinations should be requested by the patient, as this must be done via a claim filing and can take up to six to eight weeks. Any and all surgery appointments must be after the pre-authorizations or pre-determination is received back from the insurance company. Remember, this must be requested by the patient; they are not done automatically by our office.

All estimated co-payments are due in full the day the services are performed. For your convenience we accept Visa, MasterCard, personal checks, and cash. It is important for you to know that the estimated co-payment is exactly that, estimated. We give you this estimate as a courtesy so you do not have to pay full charges up front; and this by no means in payment of your balance in full. If your insurance does not pay the full amount that is pending after your co-payment, any balance is your responsibility and you will receive a statement. Again, paying your co-payment the day of surgery does not mean you are paid in full.

Most importantly, it is the patient's responsibility to be informed of what their insurance policy covers. With so many changes, a lot of them limiting benefits, and all insurance policies varying from employer to employer, it is impossible for us to know this information for you. Please check with your insurance company to see if your particular oral surgery service is covered by them. If you have dual dental policies, please make sure there are no "Non-Duplication" causes on the secondary; this sometimes means the secondary will not pay at our office. If you have any questions regarding this policy, please do not hesitate to ask a member of our front office staff. Thank you for your understanding.

**I acclaim that I have read the above statements and agree to pay the fees of this doctor and office for the services rendered.**

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Date

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Patient or Guarantor of Account

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Witness



## DOWNRIVER SURGERY CENTER

Ronald P. Morris, D.D.S.

1823 Fort St. • Wyandotte, MI 48192  
(734) 285-2550 • Fax: (734) 285-5375

**Protecting Your Confidential Health  
Information is Important to Us**

### Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

#### Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the Opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

#### So what has changed?

#### Why a privacy policy now?

#### Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

#### For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

#### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

#### Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

#### Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

#### Restrictions

*You have the right to* request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

#### Confidential Communications

*You have the right to* request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

(Over)

## **Inspect and Copy Your Health Information**

*You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.*

## **Amend Your Health Information**

*You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.*

*Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.*

## **Documentation of Health Information**

*You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.*

## **Request a Paper Copy of this Notice**

*You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time.*

*We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.*

*You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.*

## **How your HEALTH INFORMATION may be used**

### **To Provide Treatment**

*We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.*

### **To Obtain Payment**

*We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.*

### **To Conduct Health Care Operations**

*Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.*

### **Abuse or Neglect**

*We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.*

### **Public Health and National Security**

*We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.*

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_



# WELCOME TO THE DOWNRIVER SURGERY CENTER

Have you ever been a patient of our practice?  Yes  No Method of Personal Payment:  Cash  Check  Credit Card

Date: \_\_\_\_\_

**Patient:** (Mr., Mrs., Ms., Dr.) First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Nickname \_\_\_\_\_

Sex:  Male  Female Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel. # (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Tel. # (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Employer \_\_\_\_\_

Dentist \_\_\_\_\_ Ph. # \_\_\_\_\_ Medical Doctor \_\_\_\_\_ Ph. # \_\_\_\_\_

Referred by \_\_\_\_\_ Ph.# \_\_\_\_\_

Driver's Lic. # \_\_\_\_\_ Nearest relative not living with you \_\_\_\_\_ Tel. # (\_\_\_\_) \_\_\_\_\_

**Who will be responsible for your account?**  Self  Spouse  Father  Mother  Other \_\_\_\_\_

(If self, skip to next paragraph)

Name \_\_\_\_\_ Soc. Sec. \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Tel. (\_\_\_\_) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Tel.# (\_\_\_\_) \_\_\_\_\_

**PRIMARY DENTAL INSURANCE COMPANY**

Employer \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Group #: \_\_\_\_\_

Policyholder \_\_\_\_\_ Relation \_\_\_\_\_

Sex: M  F

Date of Birth: \_\_\_\_\_

I.D. #: \_\_\_\_\_ S.S. #: \_\_\_\_\_

**PRIMARY MEDICAL INSURANCE COMPANY**

Employer \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Group #: \_\_\_\_\_

Policyholder \_\_\_\_\_ Relation \_\_\_\_\_

Sex: M  F

Date of Birth: \_\_\_\_\_

I.D. #: \_\_\_\_\_ S.S. #: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE COMPANY**

Employer \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Group #: \_\_\_\_\_

Policyholder \_\_\_\_\_ Relation \_\_\_\_\_

Sex: M  F

Date of Birth: \_\_\_\_\_

I.D. #: \_\_\_\_\_ S.S. #: \_\_\_\_\_

**SECONDARY MEDICAL INSURANCE COMPANY**

Employer \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Group #: \_\_\_\_\_

Policyholder \_\_\_\_\_ Relation \_\_\_\_\_

Sex: M  F

Date of Birth: \_\_\_\_\_

I.D. #: \_\_\_\_\_ S.S. #: \_\_\_\_\_

## HEALTH HISTORY

**TO OUR PATIENTS:** Health problems that you may have or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

**Reason for today's office visit:** \_\_\_\_\_

|    |    |  |  | Yes                      | No                       |
|----|----|--|--|--------------------------|--------------------------|
| A. | 1. | Are you in good health? _____ Height _____ Weight _____  |  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | 2. | Have there been any changes in your general health in the past year? _____   |  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | 3. | Are you under the care of a physician? _____ Date of last visit: _____<br>If so, for what are you being treated? _____ |  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | 4. | Have you had any serious illness, operations, or hospitalizations? If so, describe _____<br>_____                      |  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | 5. | Do you have a prosthetic joint/implant? If so, describe where _____  |  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | 6. | Have you had a heart valve replacement or vascular graft? _____  |  | <input type="checkbox"/> | <input type="checkbox"/> |

| B. | HAVE YOU HAD OR DO YOU CURRENTLY HAVE....        |  | Yes No |  | NOTES | HAVE YOU HAD OR DO YOU CURRENTLY HAVE.... |   | Yes No |  | NOTES |
|----|--|--|--------|--|-------|---|---|--------|--|-------|
|    |  |  |        |  |       |   |   |        |  |       |
| 1  | Rheumatic fever?                                 |  |        |  |       | 27  | Stroke?   |        |  |       |
| 2  | Damaged heart valves ?<br>mitral valve prolapse? |  |        |  |       | 28  | Thyroid trouble?  |        |  |       |
| 3  | Heart murmur?                                    |  |        |  |       | 29  | Diabetes?   |        |  |       |
| 4  | High Blood Pressure?                             |  |        |  |       | 30  | Low blood sugar?  |        |  |       |
| 5  | Low Blood Pressure?                              |  |        |  |       | 31  | Kidney trouble?   |        |  |       |
| 6  | Chest Pain, angina                               |  |        |  |       | 32  | Are you on dialysis?  |        |  |       |
| 7  | Heart attack(s)?                                 |  |        |  |       | 33  | Swollen ankles, arthritis or<br>joint disease?                |        |  |       |
| 8  | Irregular heart beat?                            |  |        |  |       | 34  | Stomach ulcers?   |        |  |       |
| 9  | Cardiac pacemaker?                               |  |        |  |       | 35  | Contagious diseases?  |        |  |       |
| 10 | Heart surgery?                                   |  |        |  |       | 36  | Sexually transmitted diseases?                                |        |  |       |
| 11 | Bronchitis, chronic cough?                       |  |        |  |       | 37  | Problems with the immune system?                              |        |  |       |
| 12 | Asthma?  |  |        |  |       | 38  | Delay in healing?   |        |  |       |
| 13 | Hay fever / Sinus problems?                      |  |        |  |       | 39  | A tumor or growth?  |        |  |       |
| 14 | Tuberculosis?                                    |  |        |  |       | 40  | X-Ray treatment / chemotherapy?                               |        |  |       |
| 15 | Emphysema?                                       |  |        |  |       | 41  | Chronic fatigue / night sweats?                               |        |  |       |
| 16 | Difficult breathing / other lung trouble         |  |        |  |       | 42  | Are you on a diet?  |        |  |       |
| 17 | Do you smoke?                                    |  |        |  |       | 43  | A history of drug abuse?                                      |        |  |       |
| 18 | Blood transfusion?                               |  |        |  |       | 44  | A history of alcohol abuse?                                   |        |  |       |
| 19 | Blood disorder such as anemia?                   |  |        |  |       | 45  | Contact lenses?   |        |  |       |
| 20 | Bruise easily?                                   |  |        |  |       | 46  | Eye disease / glaucoma?                                       |        |  |       |
| 21 | Bleeding tendency (abnormal bleed?)              |  |        |  |       | 47  | Mental health problems?                                       |        |  |       |
| 22 | Jaundice, hepatitis or liver disease?            |  |        |  |       | 48  | A removable dental appliance?                                 |        |  |       |
| 23 | Infectious Mononucleosis?                        |  |        |  |       | 49  | Pain & Clicking of jaws when eating?                          |        |  |       |
| 24 | Gallbladder trouble?                             |  |        |  |       | 50  | Malignant Hyperthermia?                                       |        |  |       |
| 25 | Fainting spells?                                 |  |        |  |       | 51  | Have you had anything to eat or<br>drink in the last 8 hours? |        |  |       |
| 26 | Convulsions, epilepsy?                           |  |        |  |       | 52  | Who is driving you home today?                                |        |  |       |

*over* →

**C.**

**MEDICATION**

| ARE YOU NOW TAKING...                     | Yes | No | Notes | ARE YOU NOW TAKING...               | Yes | No | Notes |
|---|-----|----|-------|-------------------------------------|-----|----|-------|
| 1. Any kind of medicine, drugs, or pills? |     |    |       | 4. Tranquilizers?                   |     |    |       |
| 2. Anticoagulants?                        |     |    |       | 5. Cortisone?                       |     |    |       |
| 3. Diet Pills?                            |     |    |       | 6. Other medications (please list)? |     |    |       |

**D.**

**ALLERGIES**

| ARE YOU ALLERGIC TO OR HAD A REACTION TO...           | Yes | No | Notes | ARE YOU ALLERGIC TO OR HAD A REACTION TO...           | Yes | No | Notes |
|---|-----|----|-------|---|-----|----|-------|
| 7. Local anesthetics?                                 |     |    |       | 12. Codeine or other narcotics?                       |     |    |       |
| 8. Penicillin?  |     |    |       | 13. Other medications?                                |     |    |       |
| 9. Other antibiotics?                                 |     |    |       | 14. Allergies other than drug allergies (please list) |     |    |       |
| 10. Sodium pentothal, valium, or other tranquilizers? |     |    |       |   |     |    |       |
| 11. Aspirin?  |     |    |       |   |     |    |       |

**E.**

**WOMEN**

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 15. Is there a possibility of pregnancy? |  |  |  | 17. Are you nursing?                    |  |  |  |
| 16. Estimated delivery date ___/___/___  |  |  |  | 18. Are you taking birth control pills? |  |  |  |

**WOMEN NOTE:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

**Initials:**

Date \_\_\_\_\_

Signature of Patient  
(Parent or Guardian if minor)

Witness: \_\_\_\_\_

Doctor: \_\_\_\_\_