PATIENT REGISTRATION

Patient Name: _____ Preferred Name: _____ Birthdate: _____

SS #: _____ Emergency Contact: _____ Number: _____ Relation to Patient: _____

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

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

E-Mail Address: _____ ◯ I would like to receive correspondence via e-mail.

Male: ____ Female: _____ Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Patient's Employer: _____ Address: _____

Spouse (or parent) Name: _____ SS # _____ Phone # _____

Spouse (or parent) Employer: _____ Phone # _____

Person Responsible for Account _____ SS # _____ Birthdate: _____

Address (if different from above) _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

Do you have dental insurance? _____ Name of Primary Insurance: _____ Secondary: _____

Responsible Party is also Insurance Policy Holder for Patient? _____ Relation to Patient: _____

Whom may we thank for referring you to this Office? _____

Your General Health: _____ Excellent _____ Good ____ Fair _____ Poor. Are you currently being treated by a medical doctor: _____

If so, for what? _____

Are you currently taking medications? _____ If so, for what? _____

Name of your Medical Doctor: _____ Phone: _____

Date of last Physical Examination: _____ Date of last Dental Examination: _____

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

____ AIDS/HIV Positive
____ Alzheimer's disease
____ Anaphylaxis
____ Anemia
____ Angina
____ Arthritis/Gout
____ Artificial Heart Valve
____ Artificial Joint
____ Asthma
____ Blood Disease/Clotting
____ Breathing Problem
____ Cancer
____ Chemotherapy
____ Chest Pains
____ Cold Sores/Fever Blisters
____ Congenital Heart Disorder
____ Diabetes
____ Drug Addiction
____ Epilepsy/Seizures
____ Excessive Thirst
____ Fainting Spells/Dizziness
____ Frequent Headaches
____ Head/Neck Injury
____ Heart Trouble/Disease
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
____ Hepatitis A, B or C
____ Herpes
____ High Blood Pressure
____ Hypoglycemia
____ Kidney Problems
____ Leukemia
____ Liver Disease
____ Low Blood Pressure
____ Lung Disease
____ Mitral Valve Prolapse
____ Pain in Jaw Joints
____ Psychiatric Care
____ Sinus Trouble
____ Stomach/Intestinal Disease
____ Stroke
____ Thyroid Disease
____ Tuberculosis
____ Venereal Disease

Tobacco Use? _____ How often? _____ Alcohol Use? _____ How often? _____

Are you allergic to any of the following? ◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Latex ◯ Local Anesthetics

Do you have any other condition not mentioned above that you think we should know about? _____

_____

Payment is due when services are rendered. A finance charge will be billed on unpaid balances greater than 30 days old. All cost incurred in the collection of any outstanding balance, including but not limited to reasonable attorney fees are the responsibility of the patient and/or responsible person listed on this form.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

A $35 SERVICE CHARGE FOR CANCELLATIONS WITH LESS THAN 24 HOUR NOTICE.

X _____ Date: _____

Signature of Patient (or parent/guardian if minor)

InHealth Record Systems 12130 PR (07.11.11) To Reorder: Call 800-809-5131 (In Atlanta) 770-396-0047 (By Email) sales@inhealth.us (Online) www.inhealth.us

JOHN G. PORTSCHY, D.D.S., P.C.

2483A POWDER SPRINGS RD. · MARIETTA, GA 30064 · (770) 439-4141 · (770) 439-5326 FAX

IMPLANTS
COSMETIC DENTISTRY
CROWN & BRIDGE

MINOR ORTHODONTICS
DENTURES
FAMILY DENTISTRY

FINANCIAL POLICY

We are committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to establish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. Payment is expected at the time of service.

2. We will file your insurance for you. You will be expected to pay your estimated portion that exceeds insurance limits at the time of service. After insurance has settled and there is a remaining balance you will be responsible to take care of that balance within 60 days of date of service.

3. Please inform us of any changes in your dental insurance before each appointment.

4. We do not offer payment plans. However, if you do not have dental insurance and affordability is an issue, we offer Care Credit, which is a financing company for dental care. Please ask our front office staff for additional information regarding this option.

I acknowledge that I understand and accept this financial policy. I hereby consent for Dr. Portschy and his staff to disclose my health information to carry out payment activities in connection with any dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to John G. Portschy D.D.S.

Signature_____ Date_____

We are delighted you have chosen this office to take care of your dental needs!

JOHN G. PORTSCHY, D.D.S., P.C.

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Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have the 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.** You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of John G. Portschy, DDS, on my behalf regarding (**please check all items authorized).**

Name of authorized person(s):_____Relationship_____

Phone number_____

_____Appointments____Financial____Dental Treatment____Insurance____Other (explain)_____

Name of authorized person(s):_____Relationship_____

Phone number_____

_____Appointments____Financial____Dental Treatment____Insurance____Other (explain)_____

Authorization to Leave Health Information by Alternate Means

I authorize John G Portschy, DDS and staff to use the following telephone numbers provided on the Patient Registration Form to leave messages on voice mail for the reminder calls and other patient matters.

_____Home _____Work _____Cell phone

_____DO NOT RELEASE INFORMATION TO ANYONE : **I understand that my express consent it required to release any health care information.**

With my signature below, I acknowledge and understand that this information will be kept in my Dental record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my health provider(s) should I wish to change any contacts listed above.

Patient's Name_____Date of Birth_____

Signature of patient_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement"**

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ____/____/____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more in formation about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: _____

Telephone: _____ Fax: _____

Address: _____

Email: _____