DIAMOND DENTAL OF OWINGS MILLS, LLC
Monica Mattson, D.D.S.

WELCOME...as a new patient to our practice, we would like to welcome you. If you are an established patient, we want to thank you for the trust you have placed in Dr. Mattson and our dental team.

YOUR TREATMENT PLANNING...it is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume you are as concerned as we are about maintaining your good health.

DENTAL INSURANCE...the term is misleading. What is commonly known as "dental insurance" is more correctly termed dental benefits. Dental benefits are not intended to pay for everything, but to assist with costs of dental treatment. Generally, dental benefits pay a percentage of some procedures up to a set yearly maximum (most of which have remained the same since the early 1970's). The benefit available to you are established by which plan package your employer has purchased, and may change annually.

IMPORTANT INSURANCE INFORMATION...we recommend that you contact your insurance company for benefit information as all policies differ. Monica Mattson, D.D.S., is not listed as a "preferred provider" or "in network" for any insurance plan; however, as a courtesy to our patients we will submit claims to ALL insurance companies. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion. Please be prepared to put a percentage of your visit down along with your deductible when services are rendered. Once your insurance has paid its allowable amount, you will be responsible for the remaining balance. We do not guarantee any estimate, and we take no responsibility for any denials by the dental plans, as your plan is a contract between you and your insurance company, not us. If your insurance pays the subscriber of the policy directly, we ask that payment be made on the date of service unless financial arrangements have made in advance. **Initials____**

PAYMENT...we feel that everyone benefits when definite financial arrangements are agreed upon. For your convenience we offer several financial arrangement options. We accept personal checks, cash, Visa, MasterCard, Discover, and American Express. We also offer affordable payment plans though Care Credit third party financing. **Initials____**

APPOINTMENTS...for your convenience we offer a wide variety of office hours Monday, Tuesday, Wednesday, Thursday and some Friday and Saturday mornings. Ask about possible early morning and evening weekday hours.

CANCELLATIONS...we try to be respectful of our patient's time when scheduling appointments. Likewise, we ask you respect the time of our other patients and staff members. Please call our office as early as possible if you are in need of a schedule change or delay. Any appointment canceled with less than 24 hours of notice or a missed appointment may be subject to a $50 fee. **Initials____**

PATIENT CONFIDENTIALITY...our office is in compliance with the Federal "HIPPA" Health Insurance Portability and Accountability Act. We will not share your information with anyone other than your insurance carrier, pharmacist, physician, or other dental specialist. I have been given a copy, or have been made available the office's entire HIPPA policy. **Initials____**

I have read and understand the above policies.

____
Printed Name:

____ ____________________
Patient Signature (or Guardian signature) Date:

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name ______ Soc. Sec. # ______
Last Name *First Name* *Initial*

Address ______

City ______ State ______ Zip ______ Home Phone ______

Cell Phone ______ Email ______

Sex ❑ M ❑ F Age ______ Birthdate ______ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by ______ Occupation ______

Business Address ______ Business Phone ______

Business Email ______

Whom may we thank for referring you? ______

Notify in case of emergency ______ Home Phone ______

Cell Phone ______ Business Phone ______

Email ______

PRIMARY INSURANCE

Person Responsible for Account ______
Last Name *First Name* *Initial*

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address *(if different from patient)* ______ Home Phone ______

City ______ State ______ Zip ______

Cell Phone ______ Email ______

Person Responsible Employed by ______ Occupation ______

Business Address ______ Business Phone ______

Business Email ______

Insurance Company ______ Phone ______

Insurance Email ______

Contract # ______ Group # ______ Subscriber # ______

Name of other dependents under this plan ______

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ______ Relation to Patient ______ Birthdate ______

Address *(if different from patient)* ______ Soc. Sec. # ______

City ______ State ______ Zip ______ Home Phone ______

Cell Phone ______ Email ______

Subscriber Employed by ______ Business Phone ______

Business Email ______

Insurance Company ______ Phone ______

Insurance Email ______

Contract # ______ Group # ______ Subscriber # ______

Name of other dependents under this plan ______

Please complete both sides.

DIAMOND DENTAL OF OWINGS MILLS, LLC

Monica M. Mattson, D.D.S. **HEALTH HISTORY (Confidential)**

Name: ____________________ Today's Date: __________
Birth Date: ____________________ Date of Last Dental Exam: __________ X-Rays: ______
What is the reason for your visit? ____________________
Do you consider yourself in good health? ______ Physician: (name/contact info) ____________________
Are you happy with your smile? ______ ____________________
Have you ever smoked or used tobacco (circle) products?___ How long? ____ Qty/day? _______
Do you still smoke or use tobacco (circle) products? _______ How long? ____ Qty/day? _______
Have you ever had an oral cancer exam? ______
Are you pregnant? ________ How many weeks? ____________________
Do you suffer from migraines or muscle tension headaches? ____________ How often? ____________
Are you aware of clenching or grinding of your teeth? _____ Have you worn/wear (circle) a nightguard? ____________
Do you have a history of periodontal (gum) disease?_______
Have you ever had “deep cleanings” or root planing of your teeth? _________ When? ____________
Have you ever been pre-medicated before dental appointments? __________ Antibiotics? __________ Anxiety? ______
Do you have a dry mouth? ________
Do you drink sodas or sports drinks? ____________________ How often?____________
Do you chew gum, chew ice, bite nails, suck on hard candy or cough drops (circle)? ________ How often?____________
Do you get fever blisters or cold sores? ____________________ How often?____________
Are there any other health issues we should know about? ____________________
Health History Updates ________ ________ ________ ________ ________ ________ ________ ________ ________

CONDITIONS: Circle Conditions that you HAVE or HAD in the past.

Condition	Please Explain	Condition	Please Explain
Acid Reflux/GERD		Herpes	
AIDS		High Blood Pressure	
Alcoholism		AIDS / HIV Positive	
Anorexia		HPV	
Asthma/Inhaler		Joint Replacement/Date	
Bleeding Disorder		Kidney Disease	
Blood Transfusion		Liver Disease	
Bulimia		Migraine Headaches	
Chemical Dependence		Pacemaker/Defibrillator Implant	
Cancer/Type/Treatment		Psychiatric Care/Medication	
Diabetes/Type/Controlled?		Subacute Bacterial Endocarditis	
Emphysema		Stroke / T.I.A.	
Epilepsy		Thyroid Problems	
Heart Disease		Tuberculosis	
Heart Murmur		Ulcers	
Hepatitis/Type		Other	

Patient is responsible for notifying the dentist of any changes in their health or medications. Initials___

MEDICATIONS: (List of medication and dosages currently taking) ____________________
____
VITAMINS, SUPPLIMENTS, RECREATIONAL DRUGS: (What and how often)____________________
____
ALLERGIES: (To medications or substances)____________________
____
Do you have any scheduling preferences? ____________________
Morning, Afternoon, Evening, Weekends (circle)? M, Tu, W, Th, F, Sa? ONLY?
Communications preferences (circle)? Email, Text, Home Phone, Cell Phone, Written, Language
Personnel Requests? ____________________
Do you require any special needs while receiving care here? ____________________
Ex. wheelchair access, no stairs, blanket, no music, headphones

DIAMOND DENTAL OF OWINGS MILLS, LLC
FINANCIAL POLICY

Overview **Patient Name**________________________________

Thank you for choosing our office for your dental needs. We continually strive to provide our patients with the finest care. Dental treatment is an excellent investment in an individual's medical and psychological well-being. We work hard to discuss your dental care, the risks and benefits to various treatments, and associated fees before beginning any treatment. We realize that every patient has different financial situations; therefore, we are prepared to offer our patients a variety of payment options to allow you to receive the dental care that you deserve. To maintain efficient practice operations, and prevent any misunderstanding, we ask that you review our financial policies.

Payment for dental services provided are due at the time of service unless other arrangements have been made in advance. For patients with dental insurance, your deductible and copay are due on the date of service. We will work with you to maximize your insurance benefits, but keep in mind, you are fully responsible for all fees associated with treatment, regardless of insurance coverage.

For your convenience, we accept cash, checks, Visa, MasterCard and Care Credit (third party financing).

When a balance is due on your account, you will receive a monthly statement. After 90 days, any unpaid may be eligible for a collections agency.

Please contact our office if your statement does not reflect your insurance company's payment within the four to six weeks following your treatment. Any remaining balance after your insurance company has paid is your responsibility, and prompt payment is appreciated. Note: Adults 18-26 years old using their parent(s) insurance, financial arrangements are your responsibility, but you may want to include your parent(s) in financial discussions.

Discounts and Financing Plans

-Pay As You Go: Simply complete treatment at a pace that is comfortable with your personal finances.

-5% Pre-pay Cash or Check Discount: On treatment greater than $1500 when paid by check or cash on or before the date of service.

-3% Pre-pay Credit Card Discount: On treatment greater than $1500 when paid by credit card on or before the date of service.

-Special Service Payment Option: On occasion, the doctor may opt to allow for an extended in office payment plan. This treatment option would allow the patron to spread the payment of treatment over 3 months by paying half of the treatment cost on the date of service, then pay the remaining balance in 2 equal subsequent monthly payment. Month 1 = 50% total balance fee, Month 2 = 25% total balance fee, Month 3 = 25% total balance fee (Paid in Full). This option MUST be agreed upon BEFORE service is rendered.

-Care Credit Healthcare Financing: Healthcare financing allows you the flexibility of applying for several convenient financing plans. Upon completion a short credit application and approval by Care Credit, you may select 3, 6, or 12 months *interest free* financing, or 18-60 month plans from 4.99% to 14.90% depending on your credit score. More information may be found at www.carecredit.com

I have been presented these options: ____ Date:_______________

Signature or Guardian's Signature

HIPAA PRIVACY FORM 1

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

{NAME OF PRACTICE}

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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 your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.______ for each page, $______ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. 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 will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: ____

Telephone: ______________________ Fax: ______________________

E-mail: ____

Address: ____

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Patient HIPPA Consent For Alternate Contact

I hereby give my consent for Diamond Dental of Owings Mills to disclose protected health information ("PHI" including, for instance, appointment reminders or treatment options and finances) about me or my dependent to the following trusted persons in conformance with Diamond Dental of Owings Mills Notice of Privacy Practices ("NPP"). Diamond Dental of Owings Mills NPP more completely describes why and how such information may be disclosed. I have the right to review the Notice of Privacy Practices prior to signing this consent. Diamond Dental of Owings Mills and its affiliates reserve the right to revise the Notice of Privacy Practices at any time.

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Signature of Patient OR Legal Guardian ____

Date _________________________________

Print Patient's Name OR Print Name of Legal Guardian ____