Patient Acknowledgement and Consent Form

Frank Stankiewicz, D.D.S., P.C.,
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(313) 928-6100

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA requirements, we are giving you a copy of our condensed version of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan Law requires (in addition to or attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information that except for our disclosures in connection with: a defense to claim challenging our professional competence, a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or healthcare professional (including laboratory technician), provide as specimen to a laboratory for testing, or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

I authorize Frank Stankiewicz, D.D.S., P.C. to disclose any information including but not limited to treatment, cost/payment, medical history, etc. to ______________________________. I understand that any change to this consent must be submitted in writing.

Patient Acknowledgement

Please sign this form below under the heading "Patient Acknowledgement" to acknowledge that you have received a copy of our Notice of Privacy Practices.

Patient Name Printed: ______________________________

Patient/Guardian Signature: ______________________________ **Date:** ______________

Patient Consent

Please sign this form below under the heading "Patient Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem necessary, in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Name Printed: ______________________________

Patient/Guardian Signature: ______________________________ **Date:** ______________

FOR OFFICE USE ONLY Patient Refused to Sign or Emergency Situation

The following circumstances prohibited the patient from signing the Acknowledgement: ______________

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: ____________

E-mail Address: ____________

Name: ____________ LAST FIRST MI MR MRS MS DR

I prefer to be called: ____________ ☐ Male ☐ Female

Birthdate: __/__/__ Age: ____ SS #: ____________

Home Address: ____________ APT/CONDO #:

____________ CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: ( ) ____________ Cell #: ( ) ____________

Wk #: ( ) ____________ Ext: ____ DL #: ____________

Employer: ____________

Employer's Address: ____________

How long there? ____ Occupation: ____________

Where & when are best times to reach you? ____________

Whom may we Thank for referring you? ____________

Other family members seen by us: ____________

Previous / Present Dentist: ____________ (Please Circle)

Last Visit Date: ____________

2 Spouse Information

His / Her Name: ____________

Employer: ____________

Contact #: ( ) ____________ Ext: ____ SS #: ____________

Birthdate: __/__/__ Driver's License #: ____________

Person Responsible for Account: ____________

Contact #: ( ) ____________

Billing Address: ____________

Relation: ____________ SS #: ____________

Employer: ____________ DL #: ____________

3 Insurance Coverage

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: ( ) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: __/__/__ Insured's ID #: ____________

Insured's Employer: ____________

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: ( ) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: __/__/__ Insured's ID #: ____________

Insured's Employer: ____________

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: ____________ Relation: ____________

Wk #: ( ) ____________ Hm #: ( ) ____________

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________

Phone #: ( ) ____________ Date of last visit: ____________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: ______________________

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _______

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer / Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Treatment
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Metals
Y	N	Codeine	Y	N	Jewelry	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Tetracycline

Please list any other drugs/materials that you are allergic to: ______________________

5 DENTAL HISTORY

Why have you come to the dentist today?

____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

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

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

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

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ______________________ Date ______

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature ______________________ Date ______

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: ________ Date: ________

Doctor's Comments: ______________________

MEDICAL HISTORY UPDATE

1. Date: ________ Comments: ________________ Signature: ________
2. Date: ________ Comments: ________________ Signature: ________
3. Date: ________ Comments: ________________ Signature: ________

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FRANK
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drfrank08@sbcglobal.net

CONSENT FOR SERVICES

Please initial after each statement acknowledging that you have read and agree to the contents.

I hereby authorize the doctor and/or staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my child's dental condition(s).

_______ Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

_______ I agree to the use of local anesthetics, sedatives, and other medications as necessary. I fully understand an anesthetic agent embodies certain risks.

FINANCIAL POLICY

Thank you for choosing our office as your dental care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

_______ Full payment is due at the time of service. We accept Cash, Personal Check, Visa, MasterCard, Discover, American Express, Debit Cards, and Care Credit patient financing. Please be aware that a $25.00 fee will be charged for all returned checks.

If you do not have dental insurance, we will collect the amount due for services at each appointment. If you do have traditional dental insurance, we will do our best to confirm your coverage and you will be asked to pay only the ESTIMATED part of your bill at the time of service that we think your insurance will not cover. We will submit your claim to your insurance at no charge to you. A service charge on the unpaid balance can be charged on all accounts 60 days or more past due. Further collection activity and credit reporting will be initiated on all 90 days or more past due balances.

_______ We CANNOT guarantee what your insurance company will pay; we simply estimate the amount most insurance companies pay based on most traditional plans. We can submit a pre-treatment estimate before any major work is started (crowns, bridges, implants, dentures, etc.) to your insurance company. All major dental work is required to be paid in full before cementation or delivery.

_______ Your insurance policy is a contract between you and your insurance company. You are our patient and we will treat you, not your insurance company. If your insurance company has not paid your account in full within 60 days, the balance will be sent to you in the form of a statement. You will then have 21 days from the date of your statement to remit payment to us. Please be aware that some and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the dental provisions of your insurance plan.

_______ I understand that the co-payment or patient portion of payment is only an ESTIMATE and I will be responsible for any balance after the insurance payments are made.

_______ I understand that I will need to request in writing and pay a reasonable administrative fee if I want to have copies of my records.

_______ I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependant(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice and to be applied directly to any outstanding balance on my account.

_______ Adult patients are responsible for payment at the time of service. The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied, unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash at the time of service.

_______ In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

______ **BROKEN APPOINTMENT POLICY:** When you make your appointment, the doctors' and staffs' time is specifically reserved for you. When you cancel your appointment without giving us a 48 hour notice, the time we have reserved for your appointment cannot be replaced. Our office will charge and collect the full amount of your missed appointment fee of $25.

______ **COFIRMING APPOINTMENTS:** we do require you to contact us through phone, email, or Revenue Well to confirm your appointment. If we do not hear from you at least 24 hours before your appointment we reserve the right to give that allotted time to another patient.

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Dr. Frank Stankiewicz DDS, to use and disclose my protected health information to carry out the following:

1. Treatment including direct or indirect treatment by other healthcare providers involved in my treatment.

2. Obtaining payment from third-party payers (i.e. insurance companies).

3. The day to day healthcare operations of Dr. Frank Stankiewicz DDS.

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and discloses of my protected health information, and my rights under HIPPA. I understand the Dr. Frank Stankiewicz DDS, reserves the right to change the terms of the notice from time to time and that I may contact Dr. Frank Stankiewicz DDS at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. However, if the management of Dr. Frank Stankiewicz does not agree to these requested restrictions, then Dr. Frank Stankiewicz is not bound to comply with said restrictions.

I understand that I have the right to revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent form is not affected.

_____I have read and understand my consent to the use and disclosure of my protected health information.

Please print the name of the person who has completed and signed this form

____

_____________________________________ Patient's (or Legal Guardian's) Signature

_________________________________ Date