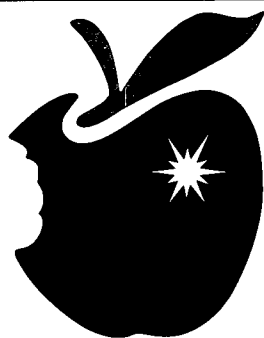


WELCOME



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 more you communicate to us, the better we are able to care for you.

...giving you a reason to smile!

ABOUT YOU

Today's Date: _____

NAME: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Driver's License #: _____

Home Address: _____
APT/CONDO# _____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm#: (____) _____ Cell #: _____

Wk#: (____) _____

Email Address: _____

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: _____

Last Visit Date: _____

What are your hobbies and interests? _____

SPOUSE OR PARENT INFORMATION

His/Her Name: _____

Employer: _____

Wk#: (____) _____ Ext: ____ SS#: _____

Person responsible for account: _____

Wk#: (____) _____ Ext: ____ Hm#: _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____ DL#: _____

DENTAL INSURANCE

We are happy to file the necessary forms to see that you receive the benefits of your coverage. However, we cannot guarantee any estimated coverage. The person responsible for the account is directly responsible for all charges.

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____

Relation: _____

Insured's Birthdate: ____/____/____

Insured's SS#: _____

Insured's Employer: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Do you need pre-medicated before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ 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

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Types of bristles? ☐ Hard ☐ Medium ☐ Soft

How would you rate your level of apprehension?

Low _____ Average _____ High _____

Are you interested in long-term Dental Care? _____

Do you want your teeth whitened? ☐ Yes ☐ No

Are you interested in cosmetic dental services? ☐ Yes ☐ No

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Tetracycline
Y N Codeine Y N Latex Y N Other
Y N Dental Anesthetics Y N Penicillin
Please list any other drugs that you are allergic to:

For Women: Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #: _____
Are you nursing? ☐ Yes ☐ No

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

Y N Abnormal Bleeding	Y N Diabetes	Y N Herpes Fever Blisters	Y N Parkinson's Disease
Y N Acid Reflux	Y N Difficulty Breathing	Y N High Blood Pressure	Y N Orthodontics (Braces)
Y N Alcohol/Drug Abuse	Y N Difficulty Sleeping	Y N HIV/AIDS	Y N Psychiatric Problems
Y N Anemia	Y N Dizziness	Y N Hospitalized for Any Reason	Y N Radiation Treatment
Y N Arthritis	Y N Emphysema	Y N Injury to Face	Y N Rheumatic Scarlet Fever
Y N Arteriosclerosis	Y N Epilepsy	Y N Injury to Mouth	Y N Seizures
Y N Artificial Bones/Joints/Valves	Y N Fainting Spells	Y N Injury to Neck	Y N Shingles
Y N Asthma	Y N Fibromyalgia	Y N Injury to Teeth	Y N Sickle Cell Disease
Y N Autoimmune Disorder	Y N Frequent Headaches	Y N Intestinal Disorders	Y N Sinus Problems
Y N Blood Transfusion	Y N Glaucoma	Y N Jaw Joint Surgery	Y N Sleep Apnea
Y N Cancer Chemotherapy	Y N Hay Fever	Y N Kidney Problems	Y N Stroke
Y N Chronic Fatigue	Y N Heart Attack	Y N Liver Disease	Y N Thyroid Problems
Y N Chronic Pain	Y N Heart Murmur	Y N Low Blood Pressure	Y N Tuberculosis (TB)
Y N Colitis	Y N Heart Surgery	Y N Meniere's Disease	Y N Ulcers
Y N Congenital Heart Defect	Y N Heart Valve Replacement	Y N Mitral Valve Prolapse	Y N Venereal Disease
Y N COPD	Y N Hemophilia	Y N Osteoporosis/Osteopenia	
Y N Depression	Y N Hepatitis	Y N Pacemaker	

Please list any other medical condition(s) not listed that you have ever had:

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS DIRECTLY TO AARON MOORE, D.D.S. I hereby authorize payment of Dental benefits, if any, otherwise payable to me, and further authorize treatment and release of all information relative to my treatment.

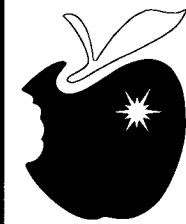
Signature _____ Date _____

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

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

His/Her Name: _____ Relation: _____

Wk#: (____) _____ Hm#: (____) _____



Dr. R.J. Moore
Dr. Aaron Moore
1414 Blizzard Drive
Parkersburg, WV 26101
(304) 424-5355

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: _____	Initial: _____	9. DATE: _____	Initial: _____
2. DATE: _____	Initial: _____	10. DATE: _____	Initial: _____
3. DATE: _____	Initial: _____	11. DATE: _____	Initial: _____
4. DATE: _____	Initial: _____	12. DATE: _____	Initial: _____
5. DATE: _____	Initial: _____	13. DATE: _____	Initial: _____
6. DATE: _____	Initial: _____	14. DATE: _____	Initial: _____
7. DATE: _____	Initial: _____	15. DATE: _____	Initial: _____
8. DATE: _____	Initial: _____	16. DATE: _____	Initial: _____

OMNIBUS Rule of 2013

HIPAA NOTICE OF PRIVACY PRACTICES

Drs. RJ & AM Moore, DDS, PLLC

The Federal Health Insurance Portability & Accountability Act of 2013, HIPAA Omnibus Rule, (formally HIPAA 1996 & HITECH of 2004) require us to maintain the confidentiality of all your healthcare records and other identifiable patient health information (PHI) used by or disclosed to us in any form, whether electronic, on paper, or spoken. HIPAA is a Federal Law that gives you significant new rights to understand and control how your health information is used. Federal HIPAA Omnibus Rule and state law provide penalties for covered entities, business associates, and their subcontractors and records owners, respectively that misuse or improperly disclose PHI.

Starting April 14, 2013, HIPAA requires us to provide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak to our HIPAA Privacy Officer. This notice takes effect 04/22/16 and will remain in effect until we replace it as authorized by law.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent Form and/or an Authorization Form of Acknowledgement of this Notice, before we will use or disclose your PHI for certain purposes as detailed in the rules below.

Documentation – You will be asked to sign an Authorization / Acknowledgement form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation Form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization / acknowledgement in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your authorization/ acknowledgement to provide services before you revoked it).

General Rule – If you do not sign our authorization/ acknowledgement form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our authorization/ acknowledgement form. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization/ acknowledgement or revoke it.

Healthcare Treatment, Payment and Operations Rule -With your signed consent, we may use or disclose your PHI in order:

- To provide you with or coordinate healthcare treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other healthcare providers, schedule lab work for you, etc.
- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment; Remember, you will be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under this new Omnibus Rule.
- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or email to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, (we will cover your name just after checking you in), we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our Privacy Officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed below and we will not use or disclose your PHI for these purposes.
- New HIPAA Omnibus Rule does not require that we provide the above notice regarding Appointment Reminders, Treatment Information or Health Benefits, but we are including these as a courtesy so you understand our business practices with regards to your (PHI) protected health information.

Special Rules - Notwithstanding anything else contained in this Notice, only in accordance with applicable HIPAA Omnibus Rule, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state or local law
- When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons
- When necessary for public health reasons (i.e. prevention or control of disease, injury or disability, reporting information such as adverse reactions to anesthesia, ineffective or dangerous medications or products, suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence)
- For federal or state government health-care oversight activities (i.e. civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.)

- For judicial and administrative proceedings and law enforcement purposes (i.e. in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death)
- For Worker's Compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a work-related injury or illness)
- For intelligence, counterintelligence or other national security purposes (i.e. Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
- For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)
- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (i.e. if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)
- To create a collection of information that is "de-identified" (i.e. it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you)
- To family members, friends and others, but only if you are present and verbally give permission. We give you an opportunity to object and if you do not, we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (i.e. you bring someone with you into the operating or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (i.e. to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (i.e. your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed. **As per HIPAA law 164.512(j)(1)... (A) is necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public and (B) is to person or persons reasonably able to prevent or lessen that threat.**

Minimum Necessary Rule - Our staff will not use or access your PHI unless it is necessary to do their jobs. All of our team members are trained in HIPAA Privacy rules. Still in certain cases, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and anyone else you list on a Consent or Authorization to receive a copy of your records
- To healthcare providers for treatment purposes (i.e. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record)
- To the U.S. Department of Health and Human Services (i.e. in connection with a HIPAA complaint)
- To others as required under federal or state law
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (i.e. clerks who copy records need access to your entire medical record)

In accordance with HIPAA law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requestor's purpose. Our Privacy Officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, our Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure
- Whether the same result could be achieved with de-identified information
- The technology available to protect confidentiality of the information
- The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requestor to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule - We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (i.e. we shred all paper containing PHI, require employees to speak with privacy precautions when discussing PHI with you, we use individual specific computer passwords and building entry codes (i.e. codes that are inactivated when an employee leaves us), we use firewall and router protection to the federal standard, we back up our PHI data off-site and encrypted to federal standard, we do not allow unauthorized access to areas where PHI is stored or filed and/or we have any unsupervised business associates sign Business Associate

Confidentiality Agreements).

However, in the event that there is a breach in protecting your PHI, we will follow Federal Guide Lines to HIPAA Omnibus Rule Standard to first evaluate the breach situation using the Omnibus Rule, 4-Factor Formula for Breach Assessment. Then we will document the situation, retain copies of the situation on file, and report all breaches (other than low probability as prescribed by the Omnibus Rule) to the US Department of Health and Human Services at:

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruc.html>

We will also make proper notification to you and any other parties of significance as required by HIPAA Law.

Business Associate Rule - Business Associates are defined as: an entity, (non-employee) that in the course of their work will directly / indirectly use, transmit, view, transport, hear, interpret, process or offer PHI for this Facility.

Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition. Under Omnibus Rule, Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us, you and the United States Department of Health and Human Services, as well as other required entities. Our Business Associates will also follow Omnibus Rule and have any of their Subcontractors that may directly or indirectly have contact with your PHI, sign Confidentiality Agreements to Federal Omnibus Standard.

Changes to Privacy Policies Rule - We reserve the right to change our privacy practices at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we created or received in the past and any in the future of the effective date. Any changes, will be posted in our office and on our website. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule - We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on our specifically worded, written Authorization / Acknowledgement Form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it via a specific Authorization Form, which may be separate from any Authorization / Acknowledgement we may have obtained from you. We will not condition your treatment here on whether you sign the Authorization (or not).

Marketing and Fund Raising Rules

Limitations on the disclosure of PHI regarding Remuneration - The disclosure or sale of your PHI without authorization is prohibited. Under the new HIPAA Omnibus Rule, this would exclude disclosures for public health purposes, for treatment / payment for healthcare, for the sale, transfer, merger, or consolidation of all or part of this facility and for related due diligence, to any of our Business Associates, in connection with the business associate's performance of activities for this facility, to a patient or beneficiary upon request, and as required by law. In addition, the disclosure of your PHI for research purposes or for any other purpose permitted by HIPAA will not be considered a prohibited disclosure if the only reimbursement received is "a reasonable, cost-based fee" to cover the cost to prepare and transmit your PHI which would be expressly permitted by law. Notably, under the Omnibus Rule, an authorization to disclose PHI must state that the disclosure will result in remuneration to the Covered Entity.

Limitation on the Use of PHI for Paid Marketing - We will, in accordance with Federal and State Laws, obtain your written authorization to use or disclose your PHI for marketing purposes, (i.e.: to use your photo in ads) but not for activities that constitute treatment or healthcare operations. To clarify, **Marketing** is defined by HIPAA's Omnibus Rule, as "a communication about a product or service that encourages recipients . . . to purchase or use the product or service." Under the Omnibus Rule, we will obtain a written authorization from you prior to recommending you to an alternative therapist, or non-associated Healthcare Covered Entity.

Under Omnibus Rule we will obtain your written authorization prior to using your PHI or making any treatment or healthcare recommendations, should financial remuneration for making the communication be involved from a third party whose product or service we might promote (i.e.: businesses offering this facility incentives to promote their products or services to you). This will also apply to our Business Associate who may receive such remuneration for making a treatment or healthcare recommendations to you. All such recommendations will be limited without your expressed written permission.

We must clarify to you that financial remuneration does not include "as in-kind payments" and payments for a purpose to implement a disease management program. Any promotional gifts of nominal value are not subject to the authorization requirement, and we will abide by the set terms of the law to accept or reject these.

The only exclusion to this would include: "refill reminders", so long as the remuneration for making such a communication is "reasonably related to our cost" for making such a communication. In accordance with law, this facility and our Business Associates will only ever seek reimbursement from you for permissible costs that include: labor, supplies, and postage. Please note that "generic equivalents", "adherence to take medication as directed" and "self-administered drug or delivery system communications" are all considered to be "refill reminders."

Face-to-face marketing communications, such as sharing with you, a written product brochure or pamphlet, is permissible under current HIPAA Law.

Flexibility on the Use of PHI for Fundraising - Under the HIPAA Omnibus Rule, 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.

Improvements to Requirements for Authorizations Related to Research - Under HIPAA Omnibus Rule, we may seek authorizations from you for the use of your PHI for future research. However, we would have to make clear what those uses are in detail. Also, if we request of you a compound authorization with regards to research, this facility would clarify that when a compound authorization is used, and research-related treatment is conditioned upon your authorization, the compound authorization will differentiate between the conditioned and unconditioned components.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION - If you got this Notice via email or website, you have the right to get, at any time, a paper copy by asking our Privacy Officer. Also, you have the following additional rights regarding PHI we maintain about you:

To Inspect and Copy - You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our Privacy Officer. Original records will not leave the premises, but will be available for inspection only during our regular business hours, and only if our Privacy Officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impractical) or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed state law to recover our costs (including postage, supplies, and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies on summary of payment of your outstanding balance for professional services if you have one. We will comply with Federal Law to provide your PHI in an electronic format within the 30 days, to Federal specification, when you provide us with proper written request. Paper copy will also be made available. We will respond to requests in a timely manner, without delay for legal review, or, in less than thirty days if submitted in writing, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (i.e. we do not have the PHI, it came from a confidential source, etc.). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed healthcare professional who is not affiliated with us, we will ensure a Business Associate Agreement is executed that prevents re-disclosure of your PHI without your consent by that outside professional.

To Request Amendment / Correction - If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a "Request for Amendment / Correction" form to our Privacy Officer. We will act on your request within 30 days from receipt but we may extend our response time (within the 30-day period) no more than once and by no more than 30 days, or as per Federal Law allowances, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (i.e. it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within 5 business days) tell you why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosure of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures - You may ask us for a list of those who got your PHI from us by submitting a "Request for Accounting of Disclosures" form to us. The list will not cover some disclosures (i.e. PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (i.e. paper or electronically) and the time period you want us to cover, which may be up to but not more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions - You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written "Request for Restrictions on Use, Disclosure" form to us (i.e. you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (i.e. we are required by law to use or disclose your PHI in a manner that you want restricted, you signed an Authorization Form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications - You may ask us to communicate with you in a different way or at a different place by submitting a written "Request for Alternative Communication" form to us. We will not ask you why and we will accommodate all reasonable requests.

To Complain or Get More Information - 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. Any concerns or questions about how we used your health information can be addressed by calling or submitting a "HIPAA Complaint" form to our privacy officer at the following:

Our Privacy Officer: Dr. Aaron M. Moore
Office Name: Moore Family Dental
Office Address: 1414 Blizard Dr., Parkersburg, WV 26101
Office Phone: 304-424-5355

These privacy practices are in accordance with the original HIPAA enforcement effective April 14, 2003, and updated to Omnibus Rule effective March 26, 2013 and will remain in effect until we replace them as specified by Federal and/or State Law.

Drs. RJ & AM Moore, DDS, PLLC

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)
- _____

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

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

FINANCIAL POLICY

Thank you for choosing our office for your dental needs! Our primary mission is to deliver the best and most comprehensive dental care available. We understand that everyone's financial situation is different, therefore, an important part of our mission is making the cost of dental care as easy and manageable as possible. For this reason, we have worked hard to provide you with a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

PAYMENT OPTIONS:

- CASH OR CHECK
- VISA/MASTERCARD/DISCOVER/DEBIT CARDS
- CARE CREDIT
Payment plans from Care Credit allow you to pay over time with
NO INTEREST, NO ANNUAL FEES, or NO PRE-PAYMENT PENALTIES.
Please ask any staff member for full details on our Care Credit plans available.

PLEASE NOTE:

R.J. Moore and A.M.Moore, LLC, requires payment upon completion of your treatment.

For any treatment requiring multiple appointments (such as dentures, partials, crowns, and bridges), a "pay as you go" payment arrangement can be provided.

Any treatment requiring the use of a dental laboratory, you must have a deposit made, at the time of service, to cover our lab costs. This deposit is necessary even if your insurance is estimated to pay in full for your treatment.

For our patients with dental insurance, we are happy to work with your carrier to maximize your benefits. We will directly bill them for reimbursement for your treatment. However, any portion that your insurance is not expected to cover, is due from you at the time of service. Any computer estimate or written estimate from your insurance company is just that, AN ESTIMATE, and NOT A GUARANTEE OF PAYMENT. Because your insurance policy is an agreement between you and the insurance company, any expected payments from the insurance company not received within 60 days from completion of treatment become the responsibility of the patient, and must be paid in full. We will be happy to resubmit any claim for you once, however we must charge an administrative fee of \$25 to do this.

There will be a charge of \$35 dollars for all returned checks.

Patient or Guardian Signature

Today's Date