ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Pierson & Saunders Orthodontics Notice of Privacy Practices effective 04/11/2017

Name (please print): _____
Signature: _____
Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Pierson & Saunders Orthodontics Notice of Privacy Practices effective 04/11/2017

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____

PLEASE LIST OTHER PARTIES WITH WHOM PIERSON & SAUNDERS ORTHODONTICS CAN DISCUSS YOUR RECORDS AND FINANCIAL INFORMATION. (This includes parents, step parents, grandparents and any caretakers who can have access to this patient's records):

Name:_____ Relation to Patient:_____

Name:_____ Relation to Patient:_____

Name:_____ Relation to Patient:_____

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 _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

TWO CONVENIENT LOCATIONS

NORTH LOOP 1604 LOCATION
8358 N. Loop 1604 W, Suite 101
San Antonio, TX 78249
Office: (210) 695-1116
www.psorthotx.com

ALAMO RANCH LOCATION
11923 Culebra Road
San Antonio, TX 78253
Office: (210) 981-6264

Confidential Patient Information Form

Patient Information

Patient's Full Name _____ Nickname _____ Age _____ Date of Birth _____

☐ Male ☐ Female Primary Phone # _____ Secondary Phone # _____

Do you like receiving text appointment reminders? Yes No (Please circle above phone number to receive text)

Address _____ State _____ Zip Code _____

Email Address _____(parent's if minor) Dentist _____ Last Appt _____

Whom may we thank for referring you to our office? _____

School _____ Hobbies _____

Other parties who may bring patient to appointments _____ Relationship to Patient _____

Patient Privacy Concerns_____

Responsible Party *(If Responsible Party is Patient, Skip Next 5 Lines)*

Full Name _____ Date of Birth _____ Relationship to Patient _____

☐ Male ☐Female Primary Phone # _____ Secondary Phone # _____

Do you like receiving text appointment reminders? Yes No (Please circle above phone number to receive text)

Address (check if same as above ☐) _____ State _____ Zip Code _____

Email address _____

Employer _____ Occupation _____ Years employed _____

How long at current residence _____ Marital Status _____

Spouse _____ Spouse's Employer _____ Years employed _____

Spouse's relationship to patient _____ Spouse's phone number _____

Insurance Information

Insured Name _____ Date of Birth _____ SSN _____

Insurance Company _____ ID# _____ Group # _____

Insurance Company Phone Number _____ Insured Employer _____

Insurance Company Address _____

Dual Coverage? ☐ YES ☐ NO

Co-Insured Name _____ Date of Birth _____ SSN _____

Insurance Company _____ ID# _____ Group # _____

Insurance Company Phone Number _____ Insured Employer _____

Insurance Company Address _____

Patient Name: _____

MEDICAL CHECKLIST

Does the patient have or ever had any of the following medical conditions?

☐ Allergies or asthma	☐ Cancer or tumor(s)	☐ Emotional Problems	☐ Hepatitis/liver disease	☐Rheumatoid arthritis
☐ Arthritis	☐ Cleft lip/palate	☐ Epilepsy or convulsions	☐ HIV or AIDS	☐ Sleep apnea/sleep disorders
☐ Breathing difficulties	☐ Diabetes	☐ Fainting or dizziness	☐ Kidney Problems	☐ Speech problems
☐ Bleeding disorders	☐ Ear Infections	☐ Hearing problems	☐ Learning Disabilities	☐ TMJ
☐ Bone Disorders	☐ Endocrine problems	☐ Heart disease or murmur	☐ Rheumatic fever	☐ Tuberculosis

Other medical conditions not listed: _____

MEDICAL HISTORY

Circle One:

Y N Does the patient have a health problem? Please list _____

Y N Is there a history of serious illness, accident or operation? Please list _____

Y N Is the patient under a doctor's care for any problems at this time? Please list _____

Y N Is the patient currently taking any medication? Please list _____

Y N Has the patient ever taken bisphosphonate medication? Please list _____

Y N Does the patient have any allergies or drug sensitivities (latex, penicillin, etc.)? Please list _____

Y N Does the patient have frequent headaches? How often? _____

Y N Does the patient use tobacco products? _____

DENTAL HISTORY

Date of last dental exam: _____

Circle One:

Y N Has the patient had any injury to the teeth? _____

Y N Has the patient had any injury to the face, jaws, or chin? _____

Y N Does the patient currently need any dental work to be completed (such as fillings or crowns)? _____

Y N Does the patient have any missing, extracted, or extra permanent teeth? _____

Y N Does the patient have any pain, clicking, or popping noises in the jaw? _____

Y N Does the patient clench or grind their teeth? _____

Y N Does the patient suck fingers, thumb, or have a similar habit? _____

Y N Has the patient had an orthodontic consultation recently? _____

Y N Has the patient had any previous orthodontic treatment? _____

Y N Have we treated any other family members? _____

Reason for seeking orthodontic treatment:

_____

_____

_____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Phone: _____

Address: _____

SIGNATURE

Patient Signature* (*Parent's signature if minor*) _____ Date: _____

**By signing, I agree that the information is true to the best of my knowledge. I have received the Privacy Policies of* Pierson & Saunders Orthodontics*. I understand that where appropriate credit bureau reports may be obtained.*

PIERSON & SAUNDERS ORTHODONTICS
8358 N Loop 1604 W, Suite 101
San Antonio, TX 78023
smile@piersonortho.com

11923 Culebra Road, Suite 102
San Antonio, TX 78253
210-981-6264

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or manage a hospital directory, and do not create or maintain psychotherapy notes at this practice

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date 4/11/2017

This Notice of Privacy Practices applies to the following organizations.

Pierson & Saunders Orthodontics

Privacy Contact - smile@psorthotx.com, 210-695-1116

PIERSON & SAUNDERS ORTHODONTICS

Request for Release of Records

Date: _____

I, _____, hereby request and give my permission to
(Patient or Parent, Legal Guardian)

Pierson & Saunders Orthodontics to provide myself or another treating doctor/practice, any and all information which he/she may request with respect to the orthodontic care of_____.
(Patient's Name)

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental records and medical records. A photocopy of this release will be as effective and valid as the original.

Signed: _____ Date: _____
(Patient or Parent, Legal Guardian)