BOWER
FAMILY DENTISTRY LLC

Appointment and Cancellation Policy

At Bower Family Dentistry taking care of patients in a safe and timely manner is our daily purpose. Taking a customized approach means that we have to have a certain level of predictability each day. We try diligently to schedule each appointment at a time that works best for your schedule. We understand that emergencies arise, creating a change in a scheduled appointment. However, for each child to receive dedicated attention and care, we ask that patients follow the Appointment and Cancellation Policy for BFD.

- You will receive call, email or text confirming your appointment 7 days prior. Please confirm it so there is no interruption in the time. You will also receive a Reminder Call 1 day prior to the appointment.
- We will always strive to schedule any next appointments when you are in the office. Please have your calendar with you so we can look for the time that best serves you.

Late Appointments

Because we work hard to customize each and every visit, it does requires careful planning and the allocation of our team to specific patients. Late appointments negatively impact the schedule.

- If you are more than 15 minutes late, we reserve the right to reschedule the time
- Multiple late appointments will result in restricted scheduling and/or dismissal from our practice.

Missed Appointments

- We require 24 hours advanced notice of a cancellation
- If you have more than two missed appointments or short-notice cancellations, it could result in dismissal from our office and /or a $50.00 Rescheduling Fee

I have read and understand the Appointment and Cancellation Policy. I as well understand that not following this Policy may result in additional fees, and the disruption of the ability to schedule.

_____ _____

Printed Guardian Name Guardian Signature

_____

Date

Health History Form

BOWER FAMILY DENTISTRY LLC

E-mail:	Today's Date:

American Dental Association www.ada.org

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create. receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:_____

(Last) (First) Middle

Address: _____

City:_____ State:_____ Zip Code:_____

Occupation: _____ Height:_____ Weight:_____

SS# or Ins Patient ID: _____

Emergency Contact: _____

Relationship: _____ Home Phone: _____

If you are completing this form for another person, what is your relationship to that person? : _____

Do you have any of the following diseases or problems? :

	Y	N	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Y	N	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, or pressure?	☐	☐	☐
Does food or floss Catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one:	DAILY / WEEKLY / OCCASIONALLY		
Are you currently experiencing dental pain or discomfort?	☐	☐	

What is the reason for your dental visit today?

How do you feel about your smile?

Do you have earaches or neck pains? ☐ ☐ ☐

Do you have any clicking, popping or discomfort in the jaw?

Do you brux or grind your teeth?

Do you have sores or ulcers in your mouth?

Do you wear dentures or partials?

Do you participate in active recreational activies?

Have you ever had a serious injury to your head or mouth?

Date of your last dental exam :

What was done at that time? :

Date of last dental x-rays :

Do both parents have their natural teeth?

Is there anything about the dentist that you strongly dislike?

Medical Information

Are you now under the care of a physician?

Physician Name: Phone: (include area code)

Address/City/State/Zip:

Has there been any change in your general health within the past year?

If yes, what condition is being treated?

Date of last physical exam:

Have you had a serious illness, operation or been Hospitalized within the past 5 years?

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?

If so please list all, including vitamins, natural or herbal preparations and/or diet supplements

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the questions)	Y	N	DK
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfllurarmin), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐
Are you takin or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Pagets disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐

Date treatment began: _____

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?	☐	☐	☐

Allergies – are you allergic to or have you had a reaction to :

Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis?	☐	☐	☐

If so, how interested are you in stopping?

(Circle on) VERY/SOMEWHAT/NOT INTERESTED

Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours?

If yes, how much do you typically drink in a week?

WOMEN ONLY Are you:

Pregnant?	☐	☐	☐

Number of weeks:

Taking birth control or hormonal replacement:	☐	☐	☐
Nursing?	☐	☐	☐

Continued

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems:

	Y	N	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damage heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood Transfusion	☐	☐	☐
If yes, date:	☐	☐	☐
Hemophilia	☐	☐	☐
Aids or HIV Infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion			

	Y	N	DK
Chronic pain	☐	☐	☐
Diabetes Type 1 or 2	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorder	☐	☐	☐
If yes, specify	☐	☐	☐
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:	☐	☐	☐
Recurrent Infections	☐	☐	☐
Type of infection:	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form,

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments:

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Financial Agreement

Our primary goal is not to allow the cost of treatment to prevent you from being able to receive the care that they need.

Insurance

We charge what is usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health for your child.

Ultimately, however, You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. Please remember that your insurance policy is a contract between you and your insurance provider. We will, as a courtesy, bill your insurance to help you receive the maximum benefit under your policy. It is your responsibility to provide all necessary insurance identifications, understand your eligibility and notify us immediately of any changes. It's also your responsibility to ensure that our office is a participant with your insurance plan. Although we are providers of multiple PPO network plans, we do accept most insurances.

_____ Initial reading the above statement

- All Co-Pays and Deductibles will be due at the time of service
- Pre-estimates can be submitted on your behalf, please understand they are simply an **ESTIMATION** of patient cost

Do you have dental insurance that we may file on your behalf and accept assignment of payment? Yes No

Payment Options

We make payments convenient as possible by accepting Cash, Check, Master Card, Visa and American Express. Payments can be made via phone during regular office hours.

- All services without insurance submission are due in full the day of treatment
- Internal Financing is available up to three months – **a Credit Card must be placed on file**
- A $35 fee will be applied to all returned checks
- Balances over 90 days will be turned over to an external collection company
- Account must be paid in full prior to each 6-month cleaning and exam appointment

Agreement

I understand and fully agree that I am responsible for my account balance. I agree that if turned over to a collection source, I will be responsible for fees above and beyond my account which may include attorney and court fees. I understand that if my account becomes overdue or uncollected, it can result in cancelled appointment and dismissal from the practice. Lastly, if insurance is involved, I take full responsibility for any following up on any disputes I may have with their payment schedule.

_____ _____

Patient Signature Guardian Signature

_____

Date

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Patient Name: _____

Patient DOB: _____

I hereby acknowledge that I have been offered a copy of Bower Family Dentistry's Notice of Privacy Practice.

Initials of Patient/Parent/Guardian: _____

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

_____ _____

Signature Date

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representatives Name: _____

Relationship to the Patient: _____

Right to Revoke

You have the right to revoke this consent at *any time* by giving us written notice of your revocation submitted to the Contact Person listed in the Notice of Privacy Practices. Please understand that the revocation will not apply to any affect any actions taken prior to the dated revocation. We reserve the right to decline to treat you or to continue treating you if you revoke consent.

Permission to Share Medical Information

May we leave medical and appointment information via voicemail? Yes _____ No _____

Preferred Phone # _____

My Medical Information may be obtained and/or disclosed to the following people:

_____	_____
Name/Relationship	Name/Relationship
_____	_____
Name/Relationship	Name/Relationship

Initials of Patient/Parent/Guardian: _____

Permission to Bill Your Insurance

All professional services are charged to the patient. Bower Family Dentistry will help expedite insurance carrier payments by filing necessary claim forms. However, the patient is responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes Bower Family Dentistry to release necessary information to my insurance carrier.

_____	_____
Signature of Patient/Guardian	**Date**

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NOTICE OF PRIVACY PRACTICES 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

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

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
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

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.

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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 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.

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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.

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 expires.

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.

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.

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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, on our web site, and we will mail a copy to you.

Organizations This Notice of Privacy applies to all affiliated entities doing business Bower Family Dentistry.

Contact
Jane Mannies, Compliance Officer
Bower Family Dentistry, LLC 33 West Seventh Street Peru, Indiana 46970
Phone: 765-473-5300
Fax: 765-473-7845
Email:

Effective Date of this Notice: May 4, 2021

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Head of Household/ Insurance Information

Self / Patient

Name: _____ Birthdate ___/ ____/ _____

Home Address: _____

Mailing Address: _____

Social Security Number ___-___-____ Home Phone (___-___-____) Marital Status: _____

Place of Employment:_____ (___-___-____)

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

Emergency Contact Person _____ (___-___-____)

Spouse

Spouse Name: _____ Birthdate ___/ ____/ _____

Social Security Number ___-___-____ Home Phone (___-___-____)

Place of Employment:_____ (___-___-____)

Children

Name: _____

Name: _____

Name: _____

Name: _____

You are responsible for your account and any minor children on your account.

Do you have Dental Insurance? Please fill out back page if so.

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Patient Name: _____ Birthdate ___/ ____/ _____

Home Address: _____

Mailing Address: _____

Social Security Number ___-___-____ or Insurance ID_____

Is patient a Full Time Student? ____ If Yes, Name of School _____

Primary Insurance #1

Subscribers Name: _____ Birthdate ___/ ____/ _____

Social Security Number ___-___-____ or Insurance ID_____

Employer: _____ Address: _____

Insurance Carrier Name: _____

Insurance Carrier Address/ Phone: _____ (___-___-____)

Plan Number: _____ Group Number: _____

Secondary Insurance #2

Subscribers Name: _____ Birthdate ___/ ____/ _____

Social Security Number ___-___-____ or Insurance ID_____

Employer: _____ Address: _____

Insurance Carrier Name: _____

Insurance Carrier Address/ Phone: _____ (___-___-____)

Plan Number: _____ Group Number: _____

I authorize Bower Family Dentistry to file claims with insurance on my behalf if that benefit is available to me. That will include the release of information including the diagnosis, records of any treatment, propose treatment and/ or results of examinations. This release is solely for the facilitation of billing and reimbursement, directly to Bower Family Dentistry, of insurance benefits which I or my minor child are entitled to.

_____ _____

Signature of Insured or Family Representative Date

_____

Printed Name