This authorization form permits:

Mark G. Pelletier, D.D.S., P.A.
900 Lake Murray Boulevard
Irmo, SC 29063

to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ Birth Date _____
Address _____
City/State/ Zip _____

Receiving Entity or Person: Please list the entities or persons you wish to get the described information about you.	**Description of information** to be given to Entity or Person. Please check the boxes for those entities or persons you wish to get the described information about you.
Voice mail Home #_____	☐ Appointment time ☐ Other _____
Voice mail Business # _____	☐ Appointment time ☐ Other _____
Voice mail Cell phone #_____	☐ Appointment time ☐ Other _____
Employer _____ School _____	☐ Appointment or absentee information ☐ Return to work or school information
Spouse (Provide name) _____	☐ Family billing information ☐ Financial information ☐ X-Rays ☐ Medical information- please list _____ _____
Parent (Provide name) _____	☐ Family billing information ☐ Financial information ☐ X-Rays ☐ Medical information- please list _____ _____
Other (Provide name) _____ Relationship _____	☐ Financial information ☐ X-Rays ☐ Medical information- please list _____ _____ _____
Other (Provide name) _____ Relationship _____	☐ Financial information ☐ X-Rays ☐ Medical information- please list _____ _____ _____

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or _____

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:
_____

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

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Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient

NOTICE OF PRIVACY PRACTICES

For the office of

Premier Aesthetic Dentistry

Mark G. Pelletier, D.D.S., P.A.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIW IT CAREFULLY.

The Health Information Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each one of the following purposes; treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include **teeth cleaning services.**
- **Payment** means such activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of March 1, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Mark G. Pelletier, DDS, PA
P.O. Box 1181
Irmo, SC 29063
803-781-7901

For more information about HIPAA or to file a complaint:

Office Civil Rights
US Department of Health and Human Services
61 Forsyth St., S.W.
Suite 3B70
Atlanta, GA 30323

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Premier Aesthetic Dentistry

Mark G. Pelletier, D.D.S., P.A.
900 Lake Murray Blvd, Suite 200
Irmo, South Carolina 29063
803-781-7901

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Act of 1998 (HIPAA), I have certain rights regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above mentioned address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

Premier Aesthetic Dentistry

Mark G. Pelletier, D.D.S.

Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we would be pleased to assist you in receiving your maximum allowable benefits. To achieve these goals, we need your assistance and understanding of your financial arrangement with our office.

Payment for services is due at the time services are rendered, except for hygiene visits, where only your co-pay will be due that day. We will be pleased to assist you in processing your insurance claim and your reimbursement. Any remaining balance 30 (thirty) days after we have filed a claim for you becomes your responsibility and is due and payable. If you have secondary insurance, we will be happy to show you how to file these claims to be reimbursed by your secondary insurance company. A service charge of 18% per annum accrues on any portion of a balance remaining over 90 (ninety) days.

A fee of $50 will be charged for failure to keep an appointment without 24 (twenty-four) hour's notice for the third failed appointment.

Financial responsibilities with minor patients lie with the parent who accompanies the child to the appointment. We cannot bill a parent who is not present in the office. We will happily provide a statement of services and payment receipt to you upon request.

Our staff will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however:

1. Your insurance is a contract between you, your employer, and your insurance company.
2. Your employer has selected the level of insurance coverage. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover.

It is necessary to emphasize, as a dental care provider, our relationship is with you and not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

For your convenience, you may pay by cash, check, American Express, Discover, Mastercard, Visa, or Care Credit. Financing is available with approved credit. Please ask us for details.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to assist you.

I have read the above Financial Policy and agree to all payment terms. I further authorize the office to release any information concerning my treatment to my insurance company.

Print Name _____
Patient or Guardian
Signature_____

Mark G. Pelletier, D.D.S, P.A.
900 Lake Murray Blvd., Suite 200
P.O. Box 1181
Irmo, South Carolina 29063

I hereby allow the dental office of Mark G. Pelletier, D.D.S. to use my image on his website and other promotional materials.

Name_____

Address_____

City_____ State_____ Zip Code_____

Signature_____

Date_____

If you do not wish your image to be used please sign below.

Signature _____

It is our desire to provide you with the best of service. In order to accomplish this, we need your help. The forms in this packet must be filled out completely before your arrival at our office. This will ensure that you will not have a wait time and also ensures that the staff and doctor will not get behind in providing proper care to all patients.

Thank you for your cooperation.

Sincerely,

Dr. Pelletier & his Team at
Premier Aesthetic Dentistry

Patient Information

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
E-Mail: _____
Gender: ____ Marital Status: _____
Birthdate: _____ Age: _____
Soc. Sec.: _____

Responsible Party (if other than patient)

Name: _____
Soc. Sec.: _____
Birthdate: _____
Work Phone: _____
Cell Phone: _____

Insurance Information

Policy Holder: _____
Soc. Sec.: _____
Birthdate: _____
Employer: _____
City, State, Zip: _____
Dental Insurance Co.: _____

In Case of Emergency

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Physician: _____
Phone: _____

Office Use Only:

1. What is your impression of your present health? ____ Good ____ Fair ____ Poor
2. Are you under the care of a physician now? YES NO
   If yes, for what reason? _____
3. Do you take any medicine regularly? YES NO
4. Do you take Cortisone now, or in the last 6 months? YES NO
5. Have you ever had a reaction to any local anesthetic, or shot? YES NO
6. Have you ever had abnormal bleeding after tooth extraction or surgery? YES NO

7. Women - Are you pregnant? _____ Due Date _____
8. When was your last complete medical exam? _____
   Results _____
9. Can you take penicillin? YES NO
10. List all medicine you CAN NOT TAKE _____
11. List all allergies _____
12. List all medicine taken in the past year including over the counter _____
13. List all supplements _____

Have you ever had:

____ Heart Trouble	____ High Blood Pressure	____ Kidney Trouble	____ Hepatitis
____ Rheumatic Fever	____ Diabetes	____ Bleeding Trouble	____ Epilepsy
____ Angina	____ Blood Disorder	____ X-Ray Therapy	____ Tuberculosis
____ Heart Murmur	____ Respiratory Disease	____ Cancer	Other _____
(Mitral Valve Prolapse)	____ Venereal Disease	____ Ulcer	

if yes, have you had an echo cardiogram? Y / N

14. Do you have any medical problem not given above? YES NO
    If yes, please list _____
15. Are you HIV Positive? YES NO
16. Have you had intimate contact with anyone who has aids or the blood or serum of anyone diagnosed as having AIDS? YES NO
17. When was your last dental cleaning and exam? _____
18. Rate your smile on a scale of 1-10 (10 being the highest) 1 2 3 4 5 6 7 8 9 10
19. Are you required to be premedicated with antibiotics for dental procedures? YES NO
20. Are you satisfied with your previous dental care? YES NO
21. Have you had a bad dental experience? YES NO
22. Has fear of discomfort kept you from the dentist? YES NO
23. Have you ever been instructed on brushing and flossing? YES NO
24. What problems are you having with your mouth? _____

Date _____ Signature _____