Welcome
Welcome
Welcome

PERIODONTAL CENTER OF EXCELLENCE

KIP W. SAUNDERS, DDS, MS

PATIENT INFORMATION

Date ______

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name ______ M.I.____ Last Name ______ Nickname ______

Sex: ☐ Male ☐ Female Birth Date ______ Age ____ Soc. Sec. # ______ E-mail ______

Street ______ City ______ State ____ Zip ______

Home Tel.(____) ______ Cell.(____) ______ Have you ever been a patient of our practice? ☐ Yes ☐ No

Dentist ______ Medical Doctor ______ Referred By ______

Driver's Lic.# ______ Nearest relative not living with you ______ Tel.(____) ______

Employer ______ Bus. Tel.(____) ______ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

In case of emergency, please contact ______ Tel. (____) ______ Relation ______

Who will be responsible for your account?

(If self, skip to next section) ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ______

Name ______ S.S.# ______ Birth Date ______ Age ____ Tel.(____) ______

Street ______ City ______ State ____ Zip ______

Employer ______ Bus. Tel.(____) ______

Spouse or other guarantor information (*if different from above*)

Name ______ Relation ______ S.S.# ______ Birth Date ______

Street ______ City ______ State ____ Zip ______

Tel. (____) ______ Employer ______ Bus. Tel.(____) ______

INSURANCE INFORMATION

Student: ☐ Full Time ☐ Part Time ☐ Not School Name/Address ______

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ______

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Do you belong to a PPO or HMO? ☐ Yes ☐ No

PRIMARY INSURANCE COMPANY

Insurance Type: ☐ Dental ☐ Medical

Employer ______

Bus. Address ______

Bus. Tel.(____) ______ Plan ______

Ins. Co. Name ______

Address ______

______ Tel.(____) ______

Group # ______ Group Name ______

Insured Party ______ Relation ______

Sex: ☐ M ☐ F Birth Date ______

Street ______

City, State, Zip ______

Tel.(____) ______ S.S. # ______

I.D. # ______

SECONDARY INSURANCE COMPANY

Insurance Type: ☐ Dental ☐ Medical

Employer ______

Bus. Address ______

Bus. Tel.(____) ______ Plan ______

Ins. Co. Name ______

Address ______

______ Tel.(____) ______

Group # ______ Group Name ______

Insured Party ______ Relation ______

Sex: ☐ M ☐ F Birth Date ______

Street ______

City, State, Zip ______

Tel.(____) ______ S.S. # ______

I.D. # ______

DENTAL INFORMATION

Reason for today's visit: ______ Are you in pain? ☐ Yes ☐ No, For How Long? ______

Please indicate any of the following problems by checking off the corresponding box:

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Red, swollen, or bleeding gums
- ☐ A removable dental appliance
- ☐ Blisters / sores in or around the mouth
- ☐ Prolonged bleeding from an injury / extraction
- ☐ Recent infections or sore throat
- ☐ My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting
- ☐ Lost / broken filling(s)
- ☐ Teeth grinding / clenching
- ☐ Ringing in ears
- ☐ Broken / chipped tooth
- ☐ Gum disease
- ☐ Other: ______
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Burning tongue / lips
- ☐ Toothache
- ☐ Difficulty closing jaw
- ☐ Difficulty opening jaw
- ☐ Loose / shifting teeth
- ☐ Food caught between teeth
- ☐ Swelling / lumps in mouth

Last dental exam ______ Last dental x-rays ______ Times a day you brush? ____ Times a week you floss? ____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ☐ Yes ☐ No

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

MEDICAL HISTORY

Are you in good health? ☐ Yes ☐ No Height ____________ Weight __________ Are you under the care of a physician? ☐ Yes ☐ No

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N
☐ ☐ Rheumatic fever
☐ ☐ Mitral valve prolapse
☐ ☐ Heart murmur
☐ ☐ High blood pressure
☐ ☐ Low blood pressure
☐ ☐ Chest pain / Angina
☐ ☐ Heart attack(s)
☐ ☐ Irregular heart beat
☐ ☐ Cardiac pacemaker
☐ ☐ Heart surgery
☐ ☐ Bronchitis / Chronic cough
☐ ☐ Chronic fatigue / Night sweat
☐ ☐ Difficulty climbing 1-2 flightsof stairs
☐ ☐ Mental health problems
☐ ☐ Damaged heart valves

Y N
☐ ☐ Are you immunosuppressed? (possibly from transplant surg.)
☐ ☐ Asthma
☐ ☐ Hay fever / Sinus problems
☐ ☐ Snoring / Sleep apnea
☐ ☐ Respiratory problems
☐ ☐ Tuberculosis
☐ ☐ Emphysema
☐ ☐ Do you smoke
☐ ☐ Do you use chewing tobacco
☐ ☐ Blood transfusion
☐ ☐ Blood disorder
☐ ☐ Bruise easily
☐ ☐ A history of drug abuse
☐ ☐ Eye disease / Glaucoma
☐ ☐ Abnormal bleeding

Y N
☐ ☐ Problems w/ immune system? (possibly from med. / surg.)
☐ ☐ Bleeding tendency
☐ ☐ Jaundice / Liver disease
☐ ☐ Hepatitis
☐ ☐ Infectious mononucleosis
☐ ☐ Gallbladder trouble
☐ ☐ Fainting spells
☐ ☐ Convulsions / Epilepsy
☐ ☐ Stroke
☐ ☐ Thyroid trouble
☐ ☐ Diabetes
☐ ☐ A history of alcohol abuse
☐ ☐ Sexually transmitted diseases
☐ ☐ Swollen ankles
☐ ☐ Malignant hyperthermia

Y N
☐ ☐ Low blood sugar
☐ ☐ Kidney trouble
☐ ☐ Are you on dialysis
☐ ☐ Arthritis / Joint disease
☐ ☐ Osteoporosis / Osteopenia
☐ ☐ Osteonecrosis
☐ ☐ Stomach ulcers
☐ ☐ Contagious diseases
☐ ☐ Delay in healing
☐ ☐ Anemia
☐ ☐ Tumor or growth
☐ ☐ Radiation / Chemotherapy
☐ ☐ Are you on a diet
☐ ☐ Contact lenses
☐ ☐ Immune system problems

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y N
☐ ☐ Nerve pills
☐ ☐ Have you ever taken diet pills
☐ ☐ Blood thinners (Coumadin, Aspirin, Advil)
☐ ☐ Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)

Y N
☐ ☐ Pain killers (including aspirin)
☐ ☐ Tranquilizers

Y N
☐ ☐ Muscle relaxers
☐ ☐ Insulin

Y N
☐ ☐ Stimulants
☐ ☐ Antidepressants

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Are you allergic to or had a reaction to:

Y N
☐ ☐ Penicillin
☐ ☐ Valium or other tranquilizers
☐ ☐ Soy

Y N
☐ ☐ Sulfa drugs
☐ ☐ Aspirin
☐ ☐ Eggs / Yolk

Y N
☐ ☐ Local anesthetic (numbing med)
☐ ☐ Codeine or other narcotics
☐ ☐ Sulfites

Y N
☐ ☐ Sodium pentothal
☐ ☐ Latex
☐ ☐ Amoxicillin

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ☐ Yes ☐ No
2) Expected delivery date: ____________
3) Are you nursing? ☐ Yes ☐ No
4) Are you taking birth control pills: ☐ Yes ☐ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X ____________ **Reviewed by:** X ____________ **Date:** X ________

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X ____________ **Date:** X ________

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X ____________ **Date:** X ________

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X ____________ **Date:** X ________

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NOTICE OF PRIVACY PRACTICES

Periodontal Center of Excellence
Kip Saunders, D.D.S., M.S., Inc.
3 Grogan's Park Drive, Suite 103
Spring, TX 77380
(281) 292-1833 phone
(281) 292-2125 fax
frontdesk@periocenter.com

Privacy Officer: Danielle Gray

Effective Date: 08/10/2017

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical/ dental information. We make a record of the dental care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality dental care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical/ dental information. It also describes your rights and our legal obligations with respect to your medical/ dental information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Dental Practice May Use or Disclose Your Health Information

This dental practice collects health information about you and stores it in a chart [and/or on a computer][and in an electronic health record/personal health record]. This is your dental record. The dental record is the property of this dental practice, but the information in the dental record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical/ dental information about you to provide your dental care. We disclose medical/ dental information to our employees and others who are involved in providing the care you need. For example, we may share your medical/ dental information with other dentists or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical/ dental information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical/ dental information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical/ dental information about you to operate this dental practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your dental plan to authorize services or referrals. We may also use and disclose this information as necessary for dental reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical/ dental information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or dental plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical/ dental information to contact and remind you about appointments. If you are not home, we may leave this

information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical/ dental information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical/ dental information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we may be required make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury

or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this dental practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another dentist or dental group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Dental Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this dental practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this dental practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical/ dental information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this dental practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this dental practice, except that this dental practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this dental practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this dental practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region VI - Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Jorge Lozano, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf

You will not be penalized in any way for filing a complaint.

Kip W. Saunders D.D.S., M.S., Inc
Medical Information Release Form (HIPAA Release Form)

Name: ______________________________ **Date of Birth:** ____________

Release of Information

I hereby authorize Kip W. Saunders D.D.S., MS, Inc to use unsecured email and mobile phone messaging to transmit to me the following protected health information 1) Information related to the scheduling of appointments; and 2) Information related to billing and payment.

I hereby authorize that Kip W. Saunders may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

__ Home Phone:(_____)___________ __Office Phone:(_____)_____________

__Cell Phone:(_____)_____________

__ Email ____

EMERGENCY CONTACT:____

I hereby authorize that Kip W. Saunders may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff.

I hereby authorize that Kip W. Saunders may disclose my personal health information to the person I have listed as my emergency contact.

_____ **Information is not to be released to anyone**

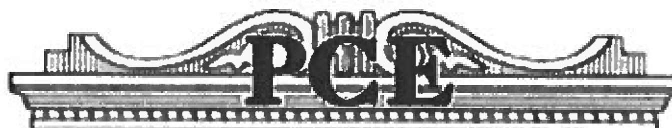
This ***Release of Information*** will remain in effect until terminated by me in writing.

I have read and understand the information in this authorization form.

Signed:____________________________________ Date: ____________

Relationship to Patient: ____

Witness: __________________________________Date: ____________



Kip W. Saunders D.D.S., M.S., Inc.

MATERIALS: I hereby authorize Dr. Kip Saunders or his assistants to photograph, videotape, audio record, broadcast, display and/or otherwise record my image, voice, likeness, name, verbal quotes, written statements, and story and information (the "Materials.")

RELEASE OF INFORMATION: I authorize use of this information regarding my dental health as part of the Materials. I understand that my private health information including diagnoses and treatment will be part of the Materials. I also expressly consent to interviewing and recording my treating dental health care provider(s) regarding my dental health information and utilizing content from those interviews for the Materials. I understand that by releasing this dental information, it may no longer be covered by the Health Insurance Portability and Accountability Act's (HIPAA) protections from further disclosures. Services from my dental providers are NOT conditioned on my signing and no services will be diminished or withheld if I do not sign below.

EXPIRATION AND REVOCATION: Dr. Kip Saunders may use the Materials and the promotional items created using the Materials until they are obsolete or until I revoke this authorization and release. I may revoke this Authorization and Release by sending a written revocation to Dr. Kip Saunders before production has begun on the promotional items created using the Materials. If I do revoke, it will not affect any Materials in production at the time of receipt of my revocation and will not be effective as to actions Dr. Kip Saunders took relying on this Authorization and Release.

COMPENSATION: I do not expect compensation, financial or otherwise, for the use of these photographs. I waive any right to royalties or other compensation arising or related to the use of the Materials.

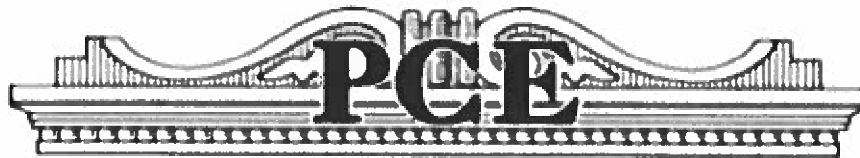
I am at least 18 years of age and am competent to contract in my own name. I have read this Authorization and Release and I understand the contents, meaning, and impact of this document.

Signature____

Printed Name ____________________________________

Date ______________________

Witness____



Kip W. Saunders D.D.S., M.S., Inc.

Hygiene Cancellation Policy

Your appointments are very important to the Periodontal Center of Excellence team. They are reserved especially for you. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24-hour notice for cancellations or rescheduling of appointments.

Please understand that when you forget, cancel, or change your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and patients on our wait list miss the opportunity to receive services.

Dr. Saunders values his staff's time. He pays his staff their entire wage for any missed or late cancelled appointment out of respect for their valuable time. Therefore, we have implemented a 24-hour cancellation and rescheduling policy.

Any appointment missed; late cancelled, or changed without 24 hour notice will result in a charge in the amount of $50.00.

As a courtesy, your appointments are confirmed electronically before your scheduled appointment by email, phone call and/or text messaging from our online appointment scheduling software. Because we know how easy it is to forget an appointment you booked months ago. We appreciate your understanding and look forward to seeing you at your next appointment.

Print Name Signature Date

Witness Date

Kip W. Saunders D.D.S., M.S., Inc.

PRIVATE CONTRACT WITH PATIENT (OPT-OUT OF MEDICARE)
EXECUTION & EFFECTIVE DATE:______________________________

PARTIES & RECITALS:

A. This is a "private contract" between Kip W. Saunders D.D.S., M.S., Inc. and ______________________________("Patient") with regard to Patient's agreement to personally pay Dentist for dental services which might be paid for by the Medicare Program.

B. Dentist is not excluded from Medicare under Sections 1128, 1156, 1892 or any other section of the Social Security Act.

C. Dentist has elected to opt-out of the Medicare program, effective April 5, 2017 and will not be eligible to participate in the program until April 5, 2019

AGREEMENTS:

A. Patient or his/her legal representative accepts full responsibility for payment of the Dentist's charge for all services furnished by the dentist.

B. Patient or his/her legal representative understands that Medicare limits do not apply to what the Dentist may charge for items or services furnished by the Dentist.

C. Patient or his/her legal representative agrees not to submit a claim to Medicare or to ask dentist to submit a claim to Medicare or Medicare supplement.

D. Patient or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by Dentist that would have or otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

E. Patient and his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

F. Patient or his/her legal representative warrants and represents that Patient does not currently require emergency care services or urgent care services.

G. Patient or his/her legal representative understands that examination and treatment by any provider they are referred to by Dr. Saunders will also not be paid for by the Medicare Program

If you are over the age of 65 please sign this form

PATIENT OR LEGAL REPRESENTATIVE:______________________________

RELATIONSHIP TO PATIENT______________________________ DATE:__________

WITNESS: ______________________________ DATE:__________