Pahls Family Dentistry

"Let our family serve yours"

Herman C. Pahls. D.D.S

Family Dentistry

Welcome

We are happy you have selected our office to serve your dental needs. Our staff works together as a friendly, dedicated team and is committed to providing quality oral health care in the most gentle and efficient manner possible.

When you make an appointment with us consider your time as "confirmed" or reserved. Should a scheduling conflict arise, Please notify our office at least 48 hours prior to your scheduled appointment so that we may reschedule you properly as well as serve our other patients.

Please be prepared to make your payment when you arrive at our office.

It is our desire to focus our efforts on patient care and not on past due accounts. We ask all of our patient, existing and new, to please follow this policy.

Payment may be made by: Cash, Check, Mastercard, VISA, American Express, Discover

If you need to make payments: You will need to apply for financing through

CareCredit (we can assist you in applying).

For those patients with insurance, we will always be happy to complete and submit all forms pertaining to your claim.

However, insurance companies, plans and benefits vary greatly and not all charges may be covered or completely paid for by insurance. Our office staff will make every attempt to give you a reasonable estimate of your portion of treatment costs. With this in mind and following the above payment guidelines, your estimated portion is also due on the day of service.

After insurance has paid their portion, any account balance is due within 10 days of the statement mailing, after which time balances will be subject to a monthly late fee of $2.00 or 18.5% APR finance charge. All account balances are due in 90 days regardless of your insurance coverage.

Please sign below that you have read and understand our office policies and that you are aware that your dental insurance is an agreement between you and the insurance company. You are responsible for paying your bill regardless of what your insurance covers.

Signed_____ Date_____

_____ Please initial here that you have received a copy of this office's Notice of Privacy Practices.

Appointment Policy

We reserve time in our schedule especially for your child and/or yourself, and in consideration of others we require at least 48 hours notice prior to cancellation of appointment. We do understand that there are circumstances that may prevent you from keeping your child's appointment, however, with providing us as much notice as possible we may be able to contact another family who would like that appointment time. You will receive one warning letter for missed appointments without proper notice being given. If a second missed appointment should occur, you will be dismissed from our practice. We ask that if you are running late, please call the office as soon as possible to verify if the appointment will need to be rescheduled. Also, *cancellations or changes to an appointment are not accepted if left on the office answering machine and the appointment will not be considered cancelled or changed unless you call during regular business hours and speak with one of our front office team members.*

Patients being seen for any appointment may have to rescheduled if they are more than 10 minutes late for their scheduled appointment time due to our consideration for other patients in the schedule.

Our goal is to make appointments of convenience for larger families. We strive for the highest quality of care and have found that parents are able to relax and focus on their children when no more than 2 of the children are being seen at a time. We allow for siblings to be scheduled at the same time as long as appointments are kept faithfully. If an appointment is cancelled or changed with less than 48 hour notice, the siblings will no longer be able to be scheduled at the same time.

We greatly appreciate your cooperation in helping us provide you with excellent care for your family. Please sign below that you have read, and acknowledge the above information provided to you. You may also have a copy for your records at your request.

Patient/Parent/Guardian:_____ Date: _____

Our Team is committed to providing exceptional dental care in a modern and comfortable environment.

"Let our family serve yours"

Health History Form

ADA
American Dental Association
www.ada.org

E-mail: Today's Date:

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)
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: (Mailing address)
City:
State:
Zip:
Occupation:
Height:
Weight:
Date of birth:
Sex: M F
SS# or Patient ID:
Emergency Contact:
Relationship:
Home Phone: ( ) *Include area codes*
Cell Phone: ( )
If you are completing this form for another person, what is your relationship to that person?
(Your Name) (Relationship)

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**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.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets 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?	☐	☐	☐

	Yes	**No**	**DK**
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 activities?	☐	☐	☐
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:

What is the reason for your dental visit today?

How do you feel about your smile?

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

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐
Physician Name: Phone: *Include area code* ( )			
Address/City/State/Zip:			
Are you in good health?	☐	☐	☐
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:			

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in 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 question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's 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: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) 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 pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

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:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
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	☐	☐	☐

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

	Yes	No	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged 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	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
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 disorders	☐	☐	☐
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	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

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

Pahls Family Dentistry
"Let our family serve yours"

346 N Central Blvd
Coquille, OR 97423
541-396-2242

Name:_____Preferred Name:_____

Birthdate: ____/____/_____ Age:_____SS#_____ M / F

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email_____

I authorize notification of appointment by automated phone call_____text_____email_____(Please Check)

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____ Minor_____ Partnered_____

Has any member of your family been (or is currently) a patient in this office? Yes / No

If yes, name: _____

Spouse or parent's name_____ Phone :_____
Employer_____ Phone #_____
Who may we thank for referring you? _____
What is the primary reason for today's visit? _____

RESPONSIBLE PARTY

Name:_____ Relationship to patient:_____

Address(if different from above)_____ City:_____ State:_____ Zip:_____

Employer:_____ Work Phone:_____ Home Phone_____

Emergency Contact Name:_____ Phone: _____

Do you have dental insurance? Y/N If yes, please fill out next page.
If no, how will you be paying for dental care? CASH / CHECK / CREDIT CARD / CARE CREDIT

To the best of my knowledge, the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to me or my child's health. It is my responsibility to inform the dental office of any changes in mine or my child's medical status, I authorize the dentist to release any information, including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of such dental care, to third party payor and/or their health practitioners.
I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my or my child's Protected Health Information to carry out treatment, payment activities and healthcare operation.

Signature:_____ **Date:**_____
Patient or Parent/Guardian

DR. PAHLS
346 N Central
Coquille, OR 97423

Consent for Treatment / Local Anesthesia

I, the undersigned patient or patient's parent/guardian, hereby authorize Dr. Pahls to perform the procedure(s) or course(s) of treatment. I understand my/my child's dental condition and have discussed the treatment options with Dr. Pahls. I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and *concerns* I have presented. I understand the *expected* results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible *consequences* of non-treatment.

I have disclosed my or my child's health history information, including allergies, reactions to medicine, *diseases,* and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I understand the risks inherent in anesthesia. I have discussed these risks with the dentist and acknowledge that they include, but are not limited to: allergic reaction, infection, bleeding, phlebitis (irritation of vein), nausea, blood clots, loss of limb function, paralysis, stroke, heart attack, brain damage, or death.

I authorize Dr. Pahls and any other qualified assistants or medical professionals to perform the procedure(s) or course(s) of treatment discussed. I am aware that treatment can change periodically and that I will be informed about any changes prior to treatment being rendered.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

_____

Date **Print Name** **Signature (patient or patient's parent/guardian)**

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
2. **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
3. **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
4. **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
5. **Military, Veterans, National Security and Intelligence**. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
6. **Workers' Compensation**. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
7. **Public Health Risks**. We may disclose health information about you for public health reason in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
8. **Health Oversight Activities**. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
9. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
10. **Law Enforcement**. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
11. **Coroners, Medical Examiners and Funeral Directors**. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.
12. **Information Not Personally Identifiable**. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
13. **Family and Friends**. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object.
14. **Deceased Person's PHI** may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent* we may have obtained from you.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time.

If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*. However, we cannot take back any uses or disclosures already made with your permission.

You have the right to be notified following a breach of your PHI by our practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Brent Pahls
346 N Central Blvd, Coquille, OR 97423
541-396-2242

You will not be penalized for filing a complaint.

Dr. Herman Pahls DDS, P.C. and Pahls Dentistry P.C

NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this notice, please contact the designated privacy officer of our office at 541-396-2242
346 N Central Blvd
Coquille, OR 97423

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your physician.

This notice is intended to inform you of how we protect, use and disclose your information, as well as to explain your right to control these disclosures.

Your Health Information

We may use and disclose health information about you without your permission for the following purposes:

1. We may disclose your information for **treatment purposes and to coordinate your medical care.**
2. We may disclose your information **to ensure that you receive insurance benefits.**
3. We may disclose your information internally **to enhance the operation of our practice.** This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information **to comply with a limited number of legal requirements**, as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested.

Effective Date: March 23, 2013

Our Duties

We are required by law to keep your information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change the terms of our Notice of Privacy Practices and to make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights

Please note that your are entitled to very specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact in order to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain limited circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

Right to Amend

If you believe our records contain errors, you may make a written request that they be amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information, unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions

You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the **Request for Restriction on Use/Disclosure of Medical Information** to our designated Privacy Officer/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form **Request for Restriction on Use/Disclosure of Medical Information** to our designated Privacy Officer/Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Officer/Contact.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list (for example, on paper or electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Complaints and Investigations

We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint you may have regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information.

You may also contact our on-site Privacy Officer/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information

We may disclose your information for the following purposes without your consent:

For Treatment Purposes

We may disclose information needed for the provision, coordination or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other health-care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management and collections activities. We may also be required to disclose your information to your insurer for review of the medical necessity, coverage, appropriateness or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. You have the right to restrict disclosures of your PHI to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing or credentialing activities
- Arranging for or conducting medical review, legal services or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Appointment Reminders

We may contact you (via voicemail messages, postcards or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.

Pahls Family Dentistry
"Let our family serve yours"
Dr. Brent Pahls and Dr. Herman Pahls
346 N. Central Street • Coquille, OR 97423 • 541-396-2242

CONCERNING INSURANCE

As a courtesy, we will assign a staff person to assist you in attempting to verify your dental insurance coverage, determine the limitations of your policy, identify your maximum dental insurance benefits, and assist you with filing the necessary forms, so that you receive the benefits to which you are entitled.

There is no guarantee of insurance coverage or payment. You should be aware that your dental insurance company does not guarantee payment, does not cover all procedures, and may not pay for any dental services provided.

By signing below, you acknowledge that you have been fully informed in advance of receiving treatment that your insurance may deny payment for some or all of the dental services that may be recommended and provided by Dr. Brent Pahls or Dr. Herman Pahls or the hygienists working with Pahls Family Dentistry. You agree to be responsible for payment in full for charges, including "Covered Services" denied coverage by your insurance.

INSURANCE INFORMATION

Patient Name_____ **Relationship to Policy Holder**_____

Patient Date of Birth_____ **Patient Social Security #**_____

Primary Insurance Holder Name_____ **Policy Holder Date of Birth**_____

Policy Holder Social Security #_____ **Employer**_____

Insurance Company_____

Group #_____ **ID #**_____ **Phone #**_____

Secondary Insurance Holder Name_____ **Policy Holder Date of Birth**_____

Policy Holder Social Security #_____ **Employer**_____

Insurance Company_____

Group #_____ **ID #**_____ **Phone #**_____

❒ I authorize and request my insurance company to pay directly to Pahls Family Dentistry unless otherwise payable to me. I understand that there is no guarantee of insurance coverage or payment and that my dental insurance carrier may deny payment or pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents. Initial_____

❒ I do not have dental insurance.

_____ _____
Signature of Patient or Guardian Date