ABOUT YOU

Today's Date: ______/______/______

Patient Name:____

LAST FIRST MI

Preferred Name:______________________ ( ) Male ( ) Female

Birthdate: ____/____/_____ Age:______ SS# ______-_____-_______

Mailing Address:____

____

CITY STATE ZIP

Home Phone #: (_____) ___________________________

Work Phone #: (_____) _________________ Ext:_______

Cell Phone #: (_____) _____________________________

E-mail Address:____

Referred By:____

Employer:________________________________ How Long:______

Employer's Address:_______________________________________

____

CITY STATE ZIP

Occupation:____

Status: ( )Single ( ) Married ( ) Divorced/Separated ( ) Widowed

Spouse's Name:____

Do you have children? ( ) Yes ( ) No How Many?______________

ACCOUNT INFO

Person ultimately responsible for account

Name:____

LAST FIRST MI

Relation:____

Billing Address:____

____

CITY STATE ZIP

SS# _____-____-______Driver's License #:____________________

Work Phone #: (_____) _________________ Ext:_______

Cell Phone #: (_____) _________________

Payment Method: ( ) Cash ( ) Check ( ) Credit Card

_______I hereby authorize assignment of my insurance rights and benefits to Gregg L. Kassan, DDS, PC for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

WELCOME TO OUR OFFICE. PLEASE TAKE A FEW MOMENTS TO COMPLETE THIS FORM SO THAT WE MAY PROVIDE YOU WITH STATE OF THE ART CARE.

INSURANCE INFO

PRIMARY INSURANCE

Co. Name:____

Address:____

____

CITY STATE ZIP

Phone #: (_____) _________________

Insured's ID#:____

Group # (Plan ID, Local #, Policy):_________________________

Insured's Name:____

Relation:______________________ Birthdate: _____/_____/______

Insured's Employer:_______________________________________

SECONDARY INSURANCE (If applicable)

Co. Name:____

Address:____

____

CITY STATE ZIP

Phone #: (_____) _________________

Insured's ID#:____

Group # (Plan ID, Local #, Policy):_________________________

Insured's Name:____

Relation:______________________ Birthdate: _____/_____/______

Insured's Employer:_______________________________________

IN EVENT OF EMERGENCY

Whom should we contact?_________________________________

Relation:____

Home Phone #: (_____) _________________________

Work Phone #: (_____) __________________________ Ext:_______

Cell Phone #: (_____) ___________________________

CONTINUE TO NEXT PAGE

DENTAL INFORMATION

Reason for today's visit: ( ) Exam ( ) Consultation ( ) Emergency Are you in pain: ( ) No ( ) Yes How long?:____________

Please indicate any of the following problems you may have:

( ) Clicking, pain, or popping in jaw ( ) Sensitive teeth or gums ( ) Red, swollen, or bleeding gums ( ) Lost or broken fillings
( ) Ringing in ears ( ) Frequent headaches or earaches ( ) Teeth grinding ( ) Blisters/Sores in or around mouth
( ) Bad breath ( ) Broken or chipped teeth ( ) Stained teeth ( ) Unhappy with appearance of teeth or smile
Previous dentist name and phone #:____ Last Dental Exam: _____/____/_____

Times a day you brush: _________ Times a week you floss:_________ What type of toothbrush do you use: ( )Soft ( )Medium ( )Hard

MEDICAL HISTORY

Medical Doctor: (Name)____ Phone# ________________________

Do you require antibiotic pre-medication? ( ) Yes ( ) No

Do you require a change in your medication before dental treatment? (ie: blood thinners, diuretics) ( ) Yes ( ) No

Are you CURRENTLY taking any of the following medications?

( ) Nerve pills ( ) Pain killers ( ) Osteoporosis meds ( ) Blood Thinners ( ) Aspirin ( ) Muscle relaxers
( ) Stimulants ( ) Insulin ( ) Tranquilizers
( ) NONE ( ) Other Medications not listed (include dosage)_____ ____

____

____

Have you EVER taken the following: ( ) Bisphosphonates (ie: Aredia/Fosamax) ( ) Phen-fen/Redux

Do you have or have you ever had any of the following:

( ) Heart Attack	( ) Kidney Problems	( ) HIV/AIDS/ARC	( ) X-ray Treatment
( ) Stroke	( ) Liver Problems	( ) Arthritis	( ) Chemotherapy
( ) Heart Murmur	( ) Sinus Problems	( ) Psychiatric Problems	( ) Asthma
( ) MVP	( ) Stomach Problems	( ) Rheumatism	( ) Difficulty Breathing
( ) Rheumatic Fever	( ) Venereal Disease	( ) Artificial Bones	( ) Diabetes
( ) Artificial Valves	( ) Alcohol Abuse	( ) Artificial Joints	( ) Hypoglycemia
( ) Heart Disease	( ) Drug Abuse	( ) Emphysema	( ) Leukemia
( ) Heart Defect	( ) Tuberculosis	( ) Fainting	( ) Anemia
( ) Chest Pains	( ) Jaw Problems/TMJ	( ) Frequent Headaches	( ) High Blood Pressure
( ) Scarlet Fever	( ) Cancer/Tumors	( ) Neck Pain	( ) Low Blood Pressure
( ) Nervousness	( ) Shingles	( ) Back Problems	( ) Bleeding Problems
( ) Thyroid Problems	( ) Hepatitis	( ) Cosmetic Surgery	( ) Glaucoma

Are you allergic to any of the following? ( ) Latex ( ) Penicillin/Amoxicillin ( ) Tetracycline ( ) Aspirin ( ) Dental Anesthetics

( ) Sulfa ( ) Foods:______________________________ ( ) Other:____

Do you use tobacco? ( )No ( )Yes How used?_________________ How much?________ How long:________

Rate your general health from 1-10:__________ Do you wear contact lenses? ( ) Yes ( ) No

FOR WOMEN: Are you taking birth control pills? ( ) Yes ( ) No How many children have you had?_______

Are you pregnant? ( ) No ( ) Yes How long:____________ Are you nursing? ( ) Yes ( ) No

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE:______________________________________ **DATE:** ________/______/________

Gregg L. Kassan D.D.S., P.C.
5077 Waterway Drive
Montclair, VA 22025

THANK YOU FOR CHOOSING OUR OFFICE!!

In an effort to efficiently & appropriately communicate our office policies with you, we ask that you read and understand the information below regarding our financial and insurance policies.
(If desired, you are welcome to request a photocopy of this signed form)

PLEASE read *and* initial on *each* line. Thank You!

Patient Name: ____ **Date:** ____
(Please print)

__________* Your dental benefits are based upon a contract between your employer and an insurance company. **If you have *any* questions regarding your dental benefits please contact your employer or insurance company directly.**

__________* We gladly accept *all* private care insurance plans (plans that do not require you to select a dentist from a list). This means we work with literally *thousands* of different insurance plans. The plans' payment methods are not made transparent to you or us, unlike how our fees are when given to you. It is impossible to give you a "100%" guaranteed quote at the time of service. We estimate your co-pay/patient portion of a service based on the most up-to-date information we have received from your dental insurance company, but, please remember, it is ***ONLY AN ESTIMATE***.
We will be happy to file a "pre-treatment estimate" with your insurance company prior to treatment, *BUT, keep in mind, this is still **not** a guarantee of coverage and it **will** delay treatment*. Any treatment plan fee estimate provided to you will be valid for 90days. The fees listed on the treatment plan provided to you, will not be changed during those 90days. IF any co-pay or insurance coverage were to change, it would be the result of a discrepancy with your insurance company.

__________* We will submit a claim to your dental insurance (with any necessary information) for services rendered to you (or your child), as a courtesy to you. Your insurance company *does not* compensate for the time & labor of the office, in doing so. If your insurance does not pay your claim(s) within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but, because your insurance policy is a legal contract between YOU and the insurance company; our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

__________* We require payment in full for your *estimated* co-pay/patient portion at the time of service. We accept Visa, MasterCard, American Express, Discover, cash & checks. We also work with Care Credit and Lending Club, outside financing companies whom offer "same as cash" options as well as financing up to 72 months (dependent upon amount financed). Part of our payment from insurance is already delayed, while your claim(s) are in process. In the event your insurance company gives a larger reimbursement then estimated, a prompt refund will be issued to you after the insurance payment arrives in our office & has been applied to your account.

__________* All balances are the responsibility of the patient (or guardian) *regardless* of insurance. Any balance not paid within 90 days of the service date (by patient or insurance) is considered past the maximum time allowable for our office to await reimbursement. Any balance remaining after 90 days is subject to collection processing and will be assessed a collection fee of $50 & any applicable late fees.

__________* When we reserve time for you to spend with our team, it is exclusively for *you*. We respect your busy schedule and unless an unforeseen dental emergency interrupts our schedule, we will be on time with your appointment. We ask that you have the same regard for us and not allow any failed appointments, late arrivals, or cancellations without proper notice. If you cancel an appointment with less than 48 hours or fail to show up for a scheduled appointment there will be a $50.00 fee for every ½ hour of appointment time missed. We ask that you call *at least* 48hours in advance should you need to change your appointment.

I understand & agree to the above listed policies. **Signed:** ________________________________ **Date:** ______________________

*****If signed by someone other *than patient*, please print NAME:** ________________________________ **RELATION:** ________________

OR

☐ **I REFUSE** to sign the Financial & Insurance Policies form for the following reason(s):

__^^ **IF box above is checked, I understand this may mean I will *not* receive care in your office.**

Signed ________________________________ **Date** ____________

Update 12/11/2014

Gregg L. Kassan, DDS, PC Notice of Privacy Practices

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. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

***Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

***Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

***Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

***Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

***Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

***Required by Law.** We may use or disclose your health information when we are required to do so by law.

***Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

***National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

***Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

***Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

***Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

***Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

***Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

***Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

***Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
***Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

***Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.
If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
***Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
***Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
***Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
***Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
***Right to Notification of a Breach**. You will receive notifications of breaches of your unsecured protected health information as required by law.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Susan Savage

Telephone: (703) 897-0463 Fax: (703) 897-1155

Address: 5077 Waterway Drive, Montclair, VA 22025

E-mail: kassandds@gmail.com

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

GREGG L KASSAN, DDS, PC
5077 Waterway Drive
Montclair, VA 22025
(703) 897-0463

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ___________________________________ **Date**:_________________________

Signature: ______________________________________

Relationship to Patient: ___________________________

Dependent family members also covered by this acknowledgement

____

- -

__**For Office Use Only:**__

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- o Patient refused to sign
- o Communication barriers
- o Emergency situation
- o Other

(see back)

Gregg L. Kassan, DDS, PC Agreement to Receive Electronic Communication

Patient Name: ____
Date of Birth:________________

Other Family Members:
____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling the office or sending an email.

Email Address (PLEASE PRINT CLEARLY):
____@_______________

Patient Signature:____

Date:__________________________

______**I choose not to receive emails from Dr. Kassan, DDS, PC**

Patient Signature:____

Date:__________________________

Gregg L. Kassan, DDS, PC

5077 Waterway Drive (703) 897-0463
Montclair, VA 22025 Fax (703) 897-1155
kassandds@gmail.com
www.drgkassan.com

Authorization to Release & Discuss Dental Information

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, and primary case physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. You may opt out by checking the "Do Not Release Information" box below.

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of Gregg L. Kassan, DDS, PC, on my behalf regarding: (please check all items authorized)

Name of authorized person(s): ______________________________
Relationship: ____________________ Phone #: ( ) ____________
___ Appointments ___ Financial ___ Dental Treatment ___Insurance

Name of authorized person(s): ______________________________
Relationship: ____________________ Phone #: ( ) ____________
___ Appointments ___ Financial ___ Dental Treatment ___Insurance

Name of authorized person(s): ______________________________
Relationship: ____________________ Phone #: ( ) ____________
___ Appointments ___ Financial ___ Dental Treatment ___Insurance

___ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my medical records and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: ________________________ Date of Birth: __________
Please print name

________________________________ Date: ______________
Signature of patient or patient's authorized representative