JACKSON dental

YOUR SMILE MATTERS

HIPAA

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

I, , am confirming that I have received a copy of the office Notice of Privacy Practices.

YOUR RIGHTS

You have the right to:

*Get a copy of your paper or electronic medical record
*Correct your paper or electronic medical record
*Request confidential communication
*Ask us to limit the information we share
*Get a list of those with whom we've shared your information
*Get a copy of this privacy notice
*Choose someone to act for you
*File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

*Tell family and friends about your condition
*Provide disaster relief
*Include you in a hospital directory
*Market our services and sell your information
*Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

*Treat you
*Run our organization
*Bill for your services
*Help with public health and safety issues
*Comply with the law
*Respond to organ and tissue donation requests
*Work with a medical examiner or funeral director
*Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical records

*You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this.
*We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

*You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
*We may say 'no' to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

*You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
*We will say 'yes' to all reasonable requests.

Ask us to limit what we use or share

*You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say 'no' if it would affect your care.

*If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say 'yes' unless a law required us to share that information.

Get a list of those with whom we've shared information

*You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.

*We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee ifyou ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

*If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

*We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

*You can complain if you feel we have violated your rights by contacting us using the information on page 1.

*You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6975, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

*We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health informati8on, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

*Share information with your family, close friends, or others involved in your case

*Share information in a disaster relief situation

*Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

*Marketing purposes

*Sale of your information

*Most sharing of psychotherapy notes

In the case of fundraising:

*We may contact your for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following way.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as

*Preventing disease

*Helping with product recalls

*Reporting adverse reactions to medications

*Reporting suspected abuse, neglect, or domestic violence

*Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

*For worker's compensation claims

*For law enforcement purposes or with a law enforcement official

*With health oversight agencies for activities authorized by law

*For specific government functions such as military, national security, and presidential protection services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

*We are required by law to maintain the privacy and security of your protected health information.

*We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

*We must follow the duties and privacy practices described in this notice and give you a copy of it.

*We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

*We never market or sell personal information

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

*Effective Date of this notice is 2016

*Contact Person: **Brenda** Telephone: **605-892-6347** or FAX: **605-892-9027**

Address: **503 Jackson Street Belle Fourche, SD 57717** Email: **drjackson@bellefourchedentist.com**

Thank you for choosing
Jackson Dental Prof LLC
As your Oral Healthcare Provider.
We are committed to your successful treatment.

The following is a statement of our office policies and consent for treatment. We require all our patients to read and sign prior to any treatment.

Payment Policy—

Full payment is due at the time of service. We gladly accept cash, check, Visa/Mastercard/Discover, American Express and Care Credit. A 5% discount is given for full payment at the time of the appointment when procedures total over $150 and are paid for using a check, money order or cash.

Insurance—

We will file your insurance claim for you providing you have supplied us with the proper information. However, your insurance is a contract among you, your employer, and the insurance company. We are not the party to contact; we file your insurance as a courtesy to you. If you file your own insurance, we will provide you with the proper information for your claim. Your portion and deductible are due the day of service. **Payment is expected regardless of whom files the claim.**

Usual and Customary Rates—

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitraty determination of usual and customary rates.**

Minor Patients—

A parent or guardian must accompany new patients that are under the age of 18 years old. The parent or guardian is responsible for full payment. The below signature grants Jackson Dental parental permission to treat the undersigned minor patient.

Appointment Policy—

We require two-business days notice to alter any reserved appointment time. In this manner, we can offer the appointment time to someone else. When we have two or less business days notice of a cancellation or we have a failed appointment we will charge your account a $25 fee for the time you had reserved.

Consent for Service—

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Upon giving us your cell phone number, you are giving us permission to call you regarding payment and insurance account information.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assistant in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumptions that our charges will be paid by any insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of patient examination.

I have had full opportunity to read and consider the contents of the Consent form and your Notice of of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure for my protected health information to carry treatment, payment activities and health care operations.
I agree to the Payment and Appointment Policies of Jackson Dental Prof LLC.

I hereby give consent for dental treatment to be completed by Dr John H Jackson, Dr Christopher J Jackson, Dr Jonathan G Krum, and their assignees.

A fee will be assessed against return checks. Any unpaid balances are subject to outside collection efforts either by a collection agency or by legal action.

Thank you and Welcome to
Jackson Dental

Patient Signature: _____ Dated:

If you are signing as a person representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
Relationship to Patient: _____

Guardian Signature: _____

Time 5:50 PM

Jackson Dental, Prof. L.L.C.

Date 4/24/2014

Eaglesoft Medical History(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now? ○ Yes ○ No If yes

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes

Do you use tobacco? ○ Yes ○ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes

If you have taken bisphosphonates when was your last dose or injection?

Are you on a special diet? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Do you have a family history of the following:

Heart Disease	○ Yes ○ No
Diabetes	○ Yes ○ No
Periodontal Disease	○ Yes ○ No
Rheumatoid Arthritis	○ Yes ○ No
Sleep Apnea	○ Yes ○ No

If you have diabetes what is your A1C level?

Do you have a family history of tuberculosis? ○ Yes ○ No

Do you or a family member have a history of blood disorders? ○ Yes ○ No

Do you snore? ○ Yes ○ No

Have you been diagnosised with Sleep Apnea? ○ Yes ○ No

Was your Sleep Apnea diagnosised as the following:

Mild	○ Yes ○ No
Moderate	○ Yes ○ No
Severe	○ Yes ○ No

Do you use a CPAP machine for your Sleep Apnea? ○ Yes ○ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No
Hepatitis	○ Yes ○ No	Renal Dialysis	○ Yes ○ No	Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No
Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Angina	○ Yes ○ No	Emphysema	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No
Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Leukemia	○ Yes ○ No
Stomach/Intestinal Disease	○ Yes ○ No	Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No
Stroke	○ Yes ○ No	Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Swelling of Limbs	○ Yes ○ No	Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No
Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Chest Pains	○ Yes ○ No
Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No
Depression	○ Yes ○ No	Venereal Disease	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No		

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____