Financial Policy

We believe in providing clear and responsible communication about financial issues. **You are responsible for all fees, including copays and deductibles, for services provided the same day of service**.

At Stoeckl Dentistry, we are committed to providing the best treatment for our guests. Our fees are based on time, materials, and continuing education for doctors and team members. You are responsible for payment regardless of your insurance company's determination of usual and customary rates. We will be happy to file claims with your insurance.

As a courtesy, we will work with you and your insurance company by getting a full run down of your dental benefits. However, it is your responsibility to know your coverage and benefits at any given time. We will provide you with the best estimate we can based on the information we receive from your insurance company for any copays or deductibles that are required. Please remember this is just an estimate. Insurance companies do not guarantee anything over the phone or in writing, and therefore any additional costs not covered by your insurance company after claims are processed are your responsibility. Please keep in mind that your insurance company has a contract with you and your employer, and not with Stoeckl Dentistry.

We accept cash, check, Visa, MasterCard, Discover, or Care Credit.

x_____ _____

(Signature of Patient or Guardian) (Date)

Stoeckl Dentistry – New Patient Health History

PLEASE COMPLETE BOTH SIDES OF THIS DENTAL/MEDICAL FORM. ALL INFORMATION IS COMPLETELY CONFIDENTIAL.

First Name_____ **Last Name** _____**MI**_____
Have you been hospitalized in the last 5 years? No / Yes Reason_____

Are you receiving medical care? If Yes, why?_____ **Last health exam:**_____
Please list names/phone numbers of doctors who are currently providing care for you..
1._____ 2._____

Please list any medications (including Herbal) you are currently taking: (1) _____
(2)_____ (3)_____ (4)_____ (5)_____

Are you taking or have you taken the following medications:

(1) Oral bisphosphonates (for tx. of osteoporosis)…
*Alendronate (Fosamax) Y /N_____ *Tiludronate (Skelid) Y/N_____
*Ibandronate (Boniva) Y/N_____ *Etidronate (Didronel) Y/N_____
*Risedronate (Actonel) Y/N_____

(2) Intravenous therapy for bone metastases of cancer and hypercalcemia of malignancy….
*Pamidronate (Aredia) Y/N_____ *Zoledronic acid (Zometa) Y/N_____

Woman: Are You Pregnant? No / Yes How far along? _____ **Are You a Nursing Mother?** No / Yes

Do You Need to Pre-Medicate / Take antibiotics one hour before your dental appts.)? No / Yes

Please Circle or List Any Allergies / Sensitivities You Have: Metal allergy: No / Yes
Latex Allergy: No / Yes Penicillin or Antibiotics: No / Yes_____
Tetracycline/Minocycline: No/Yes Milk Protein/and or hydrobenzoates: No/Yes
Other:_____

Do You Have or Have You Been Treated For Any of the Following…

Rheumatic Fever	**No / Yes**	Steroid Treatment	No / Yes
Heart Murmur	**No / Yes**	Epilepsy	No / Yes
Mitral Valve Prolapse	**No / Yes**	Glaucoma	No / Yes
Valve Replacement	**No / Yes**	Arthritis	No / Yes
Heart (Surgery, Disease, Attack)	No / Yes	Joint Disease	No / Yes
Abnormal Heart Condition	**No / Yes**	**Joint Replacement**	**No / Yes**
Abnormal Blood Pressure:	High / Low / normal	Sinus Troubles	No / Yes
Arteriosclerosis	No / Yes	Ulcers	No / Yes
Angina Pectoris	No / Yes	Cancer: Past / Current	No / Yes
Heart Pacemaker	No / Yes	Radiation Treatment	No / Yes
Stroke	No / Yes	HIV Infection/AIDS	No / Yes
Diabetes: Type I / Type II	No / Yes	Venereal Disease	No / Yes
Emphysema /Respiratory Illnesses	No / Yes	Herpes I / II	No / Yes
Asthma	No / Yes	Psychiatric Treatment	No / Yes
Tuberculosis	No / Yes	Depression / Anxiety Disorder	No / Yes
Thyroid Condition	Hyper / Hypo / normal	Eating disorders	No / Yes
Kidney Disease	No / Yes	Drug/Alcohol Addiction	No / Yes
Liver Disease	No / Yes	**Organ Transplant**	**No / Yes**
Hepatitis, A / B / C	No / Yes	Any Other Health Conditions Not Mentioned: _____	
Bleeding / Bruising Disorder	No / Yes	_____	
Anemia	No / Yes	_____	
Blood Disorder / Disease	No / Yes	_____	

Are You a Smoker? No / Yes How Much Do You Smoke Per Day? _____
Do You Chew Tobacco? No/Yes How Often? _____

Please Circle Any of the Following That Apply to Your Dental Health…

Clicking or Popping of the Jaw Joint
Pain In or Around Your Ears
Pain with Neck / Pain in Facial Muscles
Migraines
Difficulty Opening or Closing Your Mouth
Have You Ever Been Diagnosed with TMJ / TMD
Trauma to Jaw
Clench / Grind Teeth AM / PM
Difficulty Chewing
Loose Teeth
Swelling
Bleeding Gums
Bad Taste in Mouth
Bad Breath (Halitosis)
Sores / Lumps /Growths in Mouth
Food Gets Stuck Between Your Teeth
Sensitive teeth? No / Yes Hot / Cold

Please Answer the Following Dental Questions…

Have you ever had instructions in oral hygiene? No / Yes

Are you satisfied with your teeth's appearance? No / Yes _____

Are you having pain or discomfort at this time? If yes, explain _____
_____

Please take a minute and let us know if there is anything else that you feel we need to know to help make this visit more comfortable for you.

_____
_____
_____
_____
_____
_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____ _____
Signature of patient or guardian **Date**

Stoeckl Dentistry - New Guest Registration

W359 N5002 Brown St. Ste 210, Oconomowoc, WI 53066 (262)567-5600

Last Name: _____ First _____ MI_____

Mailing Address_____City_____State_____Zip_____

Sex: M/F DOB:_____Single/ Married/ Widow/Separated /Divorced

If College Student, FT/PT , where_____

Occupation_____ Employer_____

How did you hear about our office? _____

What is your previous Dentist's name? _____

Stoeckl Dentistry - Treatment Consent and Office Policy:

- I hereby authorize Stoeckl Dentistry to perform consented dental procedures. Stoeckl Dentistry understands and believes in INFORMED PATIENT CONSENT. This means that Stoeckl Dentistry will inform me of all dental treatment before initiating any dental treatment, unless it is an absolute medical emergency. Stoeckl Dentistry will also offer me alternative treatment options, advising me as to the advantages and disadvantages of the treatment and the consequences if the treatment is withheld. If during the course of executing the designated treatment unforeseen conditions arise, Stoeckl Dentistry will inform me of the change in treatment.

- If anesthetic is desired…
  I consent to the administration of local anesthesia and understand that there is a slight element of risk inherent in the administration of local anesthetic. This risk includes adverse drug response (allergic reactions), cardiac arrest, thrombophlebitis (irritation and swelling of a vein), pain, discoloration and injury to blood vessels, and possible injury to nerves (temporary to permanent numbness).

- I realize that in spite of possible complications and risks, my contemplated treatment is desired by me. I acknowledge that no guarantees have been made to me concerning the result of the procedures, as we are dealing with the human body. However, Stoeckl Dentistry stands behind their work and will do their best to give me the best possible dental treatment.

- I authorize Stoeckl Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Stoeckl Dentistry, otherwise payable to me.

- We need 48 hours notice prior to canceling or rescheduling an appointment. We understand emergencies do happen. We reserve specific time with our doctors/hygienists for your scheduled dental treatment.

- **We only place white (resin) fillings. We don't place silver-mercury (amalgam) fillings.**

- If I have any questions regarding this consent, I will ask before signing.

- I certify that I have read and understand the above information to the best of my knowledge.

X_____ _____

(SIGNATURE OF PATIENT OR GUARDIAN) (DATE)

{Stoeckl Dentistry}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, , have received a copy of this office's Notice of Privacy Practices.

{Signature or Guardian Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Your permissions authorizes the use of your health information for treatment, payment or healthcare operations. You may give us written authorization to disclose your health information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: *You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)*

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

STOECKL DENTISTRY HIPPA RELEASE FORM

PATIENT NAME _____ DATE OF BIRTH _____

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and insurance claims information. Initial all that you authorize release of information to.

_____ My insurance company

_____ Dental and medical specialists (examples include oral surgeon, root canal specialist, physician)

_____ A different dental office that I choose to see that requests my dental x-rays, records

_____ My spouse: NAME_____

_____ My children: NAME _____

_____ Other: NAME _____

_____Don't release this information to anyone. BY CHECKING THIS I UNDERSTAND THAT I WILL PAY UPFRONT FOR ALL DENTAL TREATMENT, AND I WILL SUBMIT MY OWN INSURANCE CLAIMS AND RECEIVE PAYMENT DIRECTLY FROM INSURNANCE.

This release of information will remain in effect unless terminated by me in writing.

DENTAL APPOINTMENT REMINDERS / TREATMENT MESSAGES / TREATMENT ESTIMATES:

It's Ok to contact me and/or leave detailed dental messages on the following: (Initial all that apply.)

_____ Cell Phone: Number: _____ (includes voicemail and text)

_____ Email: _____

_____ Home phone: Number: _____ (includes answering machine)

FOR MINORS:

If someone other than a parent brings my child to his/her dental appointment, Stoeckl Dentistry is authorized to discuss basic dental treatment information with them (examples: grandparents, nanny)

____ yes ____no

CONSENT:

I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this consent form, I am giving my consent to the above mentioned.

Signature: _____ Date: _____

If this consent is signed by a personal representative / guardian on behalf of the patient, complete the following:

Representative's Name:_____ Relation:_____ Date:_____

Stoeckl Dentistry - Health History

W359 N5002 Brown St. Ste 210, Oconomowoc, WI 53066 (262)567-5600

PLEASE COMPLETE BOTH SIDES OF THIS DENTAL/MEDICAL FORM. ALL INFORMATION IS COMPLETELY CONFIDENTIAL.

First Name_____ **Last Name** _____**MI**_____
Have you been hospitalized in the last 5 years? No / Yes Reason_____

Are you receiving medical care? If Yes, why?_____ **Last health exam:**_____
Please list names/phone numbers of doctors who are currently providing care for you..
1._____ 2._____

Please list any medications (including Herbal) you are currently taking: (1) _____
(2)_____ (3)_____ (4)_____ (5)_____

Are you taking or have you taken the following medications:

(1) Oral bisphosphonates (for tx. of osteoporosis)…
*Alendronate (Fosamax) Y /N_____ *Tiludronate (Skelid) Y/N_____
*Ibandronate (Boniva) Y/N_____ *Etidronate (Didronel) Y/N_____
*Risedronate (Actonel) Y/N_____
(2) Intravenous therapy for bone metastases of cancer and hypercalcemia of malignancy….
*Pamidronate (Aredia) Y/N_____ *Zoledronic acid (Zometa) Y/N_____

Woman: Are You Pregnant? No / Yes How far along? _____ **Are You a Nursing Mother?** No / Yes

Do You Need to Pre-Medicate / Take antibiotics one hour before your dental appts.)? No / Yes

Please Circle or List Any Allergies / Sensitivities You Have: Metal allergy: No / Yes
Latex Allergy: No / Yes Penicillin or Antibiotics: No / Yes_____
Tetracycline/Minocycline: No/Yes Milk Protein/and or hydrobenzoates: No/Yes
Other:_____

Do You Have or Have You Been Treated For Any of the Following…

Rheumatic Fever	**No / Yes**	Steroid Treatment	No / Yes
Heart Murmur	**No / Yes**	Epilepsy	No / Yes
Mitral Valve Prolapse	**No / Yes**	Glaucoma	No / Yes
Valve Replacement	**No / Yes**	Arthritis	No / Yes
Heart (Surgery, Disease, Attack)	No / Yes	Joint Disease	No / Yes
Abnormal Heart Condition	**No / Yes**	**Joint Replacement**	**No / Yes**
Abnormal Blood Pressure:	High / Low / normal	Sinus Troubles	No / Yes
Arteriosclerosis	No / Yes	Ulcers	No / Yes
Angina Pectoris	No / Yes	Cancer: Past / Current	No / Yes
Heart Pacemaker	No / Yes	Radiation Treatment	No / Yes
Stroke	No / Yes	HIV Infection/AIDS	No / Yes
Diabetes: Type I / Type II	No / Yes	Venereal Disease	No / Yes
Emphysema /Respiratory Illnesses	No / Yes	Herpes I / II	No / Yes
Asthma	No / Yes	Psychiatric Treatment	No / Yes
Tuberculosis	No / Yes	Depression / Anxiety Disorder	No / Yes
Thyroid Condition	Hyper / Hypo / normal	Eating disorders	No / Yes
Kidney Disease	No / Yes	Drug/Alcohol Addiction	No / Yes
Liver Disease	No / Yes	**Organ Transplant**	**No / Yes**
Hepatitis, A / B / C	No / Yes	Any Other Health Conditions Not Mentioned: _____	
Bleeding / Bruising Disorder	No / Yes	_____	
Anemia	No / Yes	_____	
Blood Disorder / Disease	No / Yes	_____	

Are You a Smoker? No / Yes How Much Do You Smoke Per Day? _____
Do You Chew Tobacco? No/Yes How Often? _____

Please Circle Any of the Following That Apply to Your Dental Health…

Clicking or Popping of the Jaw Joint
Pain In or Around Your Ears
Pain with Neck / Pain in Facial Muscles
Migraines
Difficulty Opening or Closing Your Mouth
Have You Ever Been Diagnosed with TMJ / TMD
Trauma to Jaw
Clench / Grind Teeth AM / PM
Difficulty Chewing
Loose Teeth
Swelling
Bleeding Gums
Bad Taste in Mouth
Bad Breath (Halitosis)
Sores / Lumps /Growths in Mouth
Food Gets Stuck Between Your Teeth
Sensitive teeth? No / Yes Hot / Cold

Please Answer the Following Dental Questions…

Have you ever had instructions in oral hygiene? No / Yes

Are you satisfied with your teeth's appearance? No / Yes _____

Are you having pain or discomfort at this time? If yes, explain _____
_____

Please take a minute and let us know if there is anything else that you feel we need to know to help make this visit more comfortable for you.

_____
_____
_____
_____
_____
_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____ _____
Signature of patient or guardian Date

Stoeckl Dentistry - New Guest Registration

W359 N5002 Brown St. Ste 210, Oconomowoc, WI 53066 (262)567-5600

Last Name: _____ First _____ MI_____

Mailing Address_____City_____State_____Zip_____

Sex: M/F Birth date_____ Single/ Married/ Widow/Separated /Divorced

Social Security #_____ If College Student, FT/PT , where_____

Home Phone Number: _____

Work Phone # (only write down if we can contact you at work): _____

Cell Phone Number: _____

Email Address: _____

How would you like your appointments confirmed? (PLEASE CIRCLE ALL THAT APPLY):
TEXT MESSAGE-----EMAIL----HOME PHONE

Can we leave a personal dental treatment message on your home phone or cell phone? Yes / No

Can we leave a personal dental treatment message with your spouse? Yes / No

Occupation_____ Employer_____

Employer's Address_____ City _____State_____

How did you hear about our office? _____

What is your previous Dentist's name and address? _____

If you or your child is receiving orthodontic care, please provide us with the name and phone number of your Orthodontist:
Orthodontist: _____ Phone number: _____

If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below.

Name of responsible party or parties_____

Relationship to Patient_____

Mailing address_____City_____State____Zip_____

Sex M/F Birth date_____ Single/ Married/ Widow /Separated/ Divorced

Home Phone Number_____ Work Phone Number_____

Will anyone else besides yourself or your child's other parent be bringing the child to their dental appts.?

NO / YES If yes, who will be bringing your child (i.e.: acting as guardian?)_____

Stoeckl Dentistry - Treatment Consent and Office Policy:

- I hereby authorize Stoeckl Dentistry to perform consented dental procedures. Stoeckl Dentistry understands and believes in INFORMED PATIENT CONSENT. This means that Stoeckl Dentistry will inform me of all dental treatment before initiating any dental treatment, unless it is an absolute medical emergency. Stoeckl Dentistry will also offer me alternative treatment options, advising me as to the advantages and disadvantages of the treatment and the consequences if the treatment is withheld. If during the course of executing the designated treatment unforeseen conditions arise, Stoeckl Dentistry will inform me of the change in treatment.

- If anesthetic is desired…
  I consent to the administration of local anesthesia and understand that there is a slight element of risk inherent in the administration of local anesthetic. This risk includes adverse drug response (allergic reactions), cardiac arrest, thrombophlebitis (irritation and swelling of a vein), pain, discoloration and injury to blood vessels, and possible injury to nerves (temporary to permanent numbness).

- I realize that in spite of possible complications and risks, my contemplated treatment is desired by me. I acknowledge that no guarantees have been made to me concerning the result of the procedures, as we are dealing with the human body. However, Stoeckl Dentistry stands behind their work and will do their best to give me the best possible dental treatment.

- I authorize Stoeckl Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Stoeckl Dentistry, otherwise payable to me.

- We need 48 hours notice prior to canceling or rescheduling an appointment. We understand emergencies do happen. We reserve specific time with our doctors/hygienists for your scheduled dental treatment.

- **We only place white (resin) fillings. We don't place silver-mercury (amalgam) fillings.**

- If I have any questions regarding this consent, I will ask before signing.

- I certify that I have read and understand the above information to the best of my knowledge.

X_____ _____

(SIGNATURE OF PATIENT OR GUARDIAN) (DATE)

Financial Policy

We believe in providing clear and responsible communication about financial issues. **You are responsible for all fees, including copays and deductibles, for services provided the same day of service**.

At Stoeckl Dentistry, we are committed to providing the best treatment for our guests. Our fees are based on time, materials, and continuing education for doctors and team members. You are responsible for payment regardless of your insurance company's determination of usual and customary rates. We will be happy to file claims with your insurance.

As a courtesy, we will work with you and your insurance company by getting a full run down of your dental benefits. However, it is your responsibility to know your coverage and benefits at any given time. We will provide you with the best estimate we can based on the information we receive from your insurance company for any copays or deductibles that are required. Please remember this is just an estimate. Insurance companies do not guarantee anything over the phone or in writing, and therefore any additional costs not covered by your insurance company after claims are processed are your responsibility. Please keep in mind that your insurance company has a contract with you and your employer, and not with Stoeckl Dentistry.

We accept cash, check, Visa, Mastercard, Discover, or Care Credit.

x_____ _____

(Signature of Patient or Guardian) (Date)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT: Name _____

Address: see New Patient Registration Form Patient Number: see New Patient Registration From

Persons Involved in Care:

List individuals who you would like involved in your dental care. By writing their names on this form, you consent to the release of your dental information to them. (For example, if you want us to be able to discuss dental information with your husband/wife, you must list their names below. This includes discussing fillings, crowns, insurance payments with them.) In addition, the account holder (not necessarily the insurance holder) may receive basic dental treatment information on mailed billing statements (example… John had cleaning on 1/1/07, Mary had filling on 1/1/07).

_____ _____

_____ _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. If you decide not to sign this consent, we may decline to treat you.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Christopher Stoeckl. Telephone: 262-567-5600. Fax: 262-567-5566. Address: W359 N5002 Brown Street, Oconomowoc, WI

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you if you revoke this Consent.

CONSENT

I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative / guardian on behalf of the patient, complete the following:

Personal Representative's Name: _____ Date:_____

Relationship to Patient_____

{Stoeckl Dentistry}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Signature or Guardian Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

FOR YOUR INFORMATION ONLY. NO SIGNATURES NEEDED.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Your permissions authorizes the use of your health information for treatment, payment or healthcare operations. You may give us written authorization to disclose your health information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: *You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)*

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).