DOUGLAS R. BOWMAN, DDS, MS

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 June 1, 2002, 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: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it 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.

(continued)

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 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 June 1, 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 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.

Contact Officer: Douglas R. Bowman, DDS, MS Phone: (419) 332-1303

Address: 1229 Napoleon Street ~ Fremont, OH 43420

Douglas R. Bowman, DDS, MS

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.

_____
Please Print Name

_____
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)

_____

_____

_____

Welcome to Gentle Caring Dentistry!

Office Policy

AGREEMENT FOR PAYMENT FOR SERVICES:

Full payment for services is due at the time of service, and collected at the beginning of each appointment. Any insurance co-payments are due at time of service. You must provide your insurance and identification-at-each visit, which is subject for verification prior to your appointment time. Gentle Caring Dentistry reserves the right to cancel your appointment if proof of insurance cannot be verified or is not provided or require full visit fee be paid prior to your appointment.

Co-Insurance- A percentage of your visit which is estimated on the amount your insurance discount allows for the type of service you are receiving. This amount will change from visit to visit depending on the services you are scheduled for, or if treatment changes from what was originally scheduled.

Self-Pay- When you do not have an insurance discount plan, you will be quoted an amount for your services scheduled. This amount could increase or decrease if treatment changes for any reason. Our staff will make sure you are aware of any additional costs before you agree to any treatment.

SCHEDULING AGREEMENT:

In order for Gentle Caring Dentistry's staff to schedule you in a timely manner and allow for timely follow up appointments, it is your responsibility to communicate when you are unable to keep your appointments not only as a courtesy to your provider and other patients, but also for administrative purposes as our staff prepares for each and every patient visit. Please be advised that 3 no shows can result in discharge from the practice.

24 hour notice must be provided to cancel an appointment or a missed appointment fee of $50.00 will be charged to your account and you may not be able to reschedule the missed appointment until this fee is taken care of.

UNDERSTANDING YOUR COSTS:

While Gentle Caring Dentistry staff strives to make sure all of of your financial obligations for services are clearly explained to you prior to your visit, **it is your responsibility as a patient to understand what your insurance covers and does not.** Gentle Caring Dentistry recommends you contact your insurance company by calling the number listed on your insurance card and inquire about your dental benefits as far as coverage percentages, frequencies, any age limitations, or waiting periods for services. This will help you to be aware of any costs that may become your responsibility due to any limitations or stipulations your insurance plan may have that have been negotiated by your employer.

We bill insurance as a courtesy. Dental insurance is a contract between the employer and the patient. It has no connection at all to us as your dental office. The extent of coverage varies greatly from company to company, sometimes, even within a company. It has absolutely nothing to do with the level of service provided by us, and the fee charged for these services.

An often-misunderstood term used by many insurance companies is "UCR". This means **Usual Customary** and **Reasonable**. What this means is that the insurance company places a set fee for each dental procedure. If the fee is above their "UCR" then the patient is responsible for anything the insurance does not take care of. Despite our best efforts at giving you an accurate **estimate,** a patient will owe the amount of the difference. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by your employer and decided upon by the insurance company.

I also understand and acknowledge that I am personally responsible to pay Gentle Caring Dentistry in full for services that my dental insurer will not cover due to non-payment of my dental insurance premiums.

OUTSTANDING BALANCES:

Gentle Caring Dentistry requires all outstanding balances to be paid in full prior to scheduling. We reserve the right to deny services until accounts are paid in full. Not fulfilling financial obligations to our office is also grounds for discharge from the practice. If there is ever a credit balance on your account at anytime and you are still receiving treatment please note that the credit will be applied to future fees incurred. Overpayments on accounts will be refunded if no longer receiving services within a period of six months.

OTHER COSTS:

Any returned check or reoccurring credit card payment with insufficient funds will result in an additional fee of $35.00 and you will no longer be able to pay with that form of payment.

STATEMENTS: Each month you will receive a statement for your portion of any bill that is due within 20 days of receipt. You will be asked at your next appointment for any outstanding balance payment in full unless prior arrangements for payments have already been made. If you ever have any questions about your bill or you have the need to make payment arrangements due to hardship, loss of insurance, job or other, please contact our billing department and we will be happy to assist you in your options for continuing your care.

COMMUNICATION: We use a system called Smile Reminder that will send email and text message reminders for any scheduled appointments or when you are past due for services. You can easily reply to the messages. We do ask however that you do not use this service to cancel appointments. All cancellations must be made by contacting the office directly by phone at 419-332-1303 where messages can be left if a staff member is not available to take your call.

I HAVE READ, UNDERSTAND, AND ACCEPT THE TERMS OF THE ABOVE OUTLINED POLICIES FOR INSURANCE HANDLING AND FINANCIAL COMMITMENTS THAT I MAY INCUR AS A RESULT OF TREATMENT. I KNOW THAT ANYTHING INSURANCE DOES NOT COVER IS MY RESPONSIBILITY. IF NO INSURANCE, I KNOW THAT ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I KNOW THAT IF I DON'T PAY MY OUTSTANDING BALANCE, AND THE ACCOUNT IS SENT TO COLLECTION OR SMALL CLAIMS COURT, I WILL BE RESPONSIBLE FOR ANY LATE CHARGE (18% PER ANNUM INTEREST RATE), ATTORNEY FEES OR COLLECTION FEES THAT MAY BE INCURRED.

GENTLE CARING DENTISTRY
CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care options. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protections of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other financial arrangements or agreements have been made. In the event payments are not received by agreed upon dates, or accounts go over 60 days past due, I understand that a 1 ½ % late charge (18% APR) may be added to the account.

Patients Signature _____Date _____

Parent/Responsible Party's Signature _____Date_____

Relationship to Patient _____

Gentle Caring Dentistry

Welcome to our practice!! As a new patient we have a standard protocol of treatment to establish you into our dental office. For children 18 and under we do need a signed consent of treatment. Our recommended treatment to officially fully diagnose the patient properly is as follows:

_____x_____ Comprehensive Examination

_____x_____ Any x-rays needed

_____x_____ Fluoride treatment

Please sign and date that you understand this protocol so that we will not have to question this if you are not able to come to every appointment with your child. This is only for the new patient, not for any other treatment the doctor may have to perform at another appointment. Thank you for your cooperation in this matter.

Signature _____

Print Name _____

Relationship to Patient _____

Best number and time to reach you _____

Date _____

CHILD PATIENT INFORMATION

DATE_____

CHILD'S NAME: _____
GENDER (M/F): _____
BIRTHDATE_____ AGE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
PHONE #'S: HOME#:_____ EMERGENCY#:_____
SCHOOL: _____

PARENTAL INFORMATION

PERSON RESPONSIBLE FOR SCHEDULING & BRINGING CHILD TO APPOINTMENTS AND PAYMENT OF ACCOUNT: _____

FATHER'S NAME: _____ S.S.#: _____
MARITAL STATUS: _____ BIRTHDATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE:_____
PHONE #'S: HOME_____WORK_____CELLULAR_____
FATHER EMPLOYED BY: _____
MOTHER'S NAME: _____ S.S.#: _____
MARITAL STATUS: _____ BIRTHDATE: _____
ADDRESS: _____
CITY _____ STATE _____ ZIP CODE_____
PHONE #'S: HOME_____WORK_____CELLULAR_____
MOTHER EMPLOYED BY: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE:
PATIENT'S RELATIONSHIP TO INSURED:
SELF _____ SPOUSE _____ CHILD _____ OTHER _____
NAME OF INSURED: _____
INSURED'S BIRTH DATE: _____ SS#: _____
INSURED'S ADDRESS:_____
EMPLOYER: _____

SECONDARY INSURANCE:
PATIENT'S RELATIONSHIP TO INSURED:
SELF _____ SPOUSE _____ CHILD _____ OTHER _____
NAME OF INSURED: _____
INSURED'S BIRTH DATE: _____ SS#: _____
INSURED'S ADDRESS: _____
EMPLOYER: _____

(OVER)

HEALTH HISTORY

NAME OF MEDICAL DOCTOR: _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE …… YES NO

ARE YOU TAKING ANY MEDICATION INCLUDING BIRTH CONTROL PILLS YES NO

NAMES OF MEDICATIONS: _____

DO YOU USE ANY RECREATIONAL DRUGS, INCLUDING COCAINE …… YES NO

ARE YOU AN ALCHOHOLIC ……. YES NO

DO YOU USE ANY TOBACCO PRODUCTS ……. YES NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

ALLERGIES, INCLUDING ANY MEDICATIONS …… YES NO

IF ALLERGIES, TO WHAT? _____

METAL REACTIONS …… YES NO

HEART DISEASE ……. YES NO

IF YES, WHAT TYPE? _____

RHEUMATIC FEVER ……. YES NO

HEART MURMER ……. YES NO

IF YES, WHAT TYPE? _____

HAVE YOU HAD HEART VALVE PROBLEMS INCLUDING MVP OR VALVE REPLACEMENT …… YES NO

HIGH BLOOD PRESSURE …….. YES NO

KIDNEY DISEASE …….. YES NO

LIVER DISEASE …….. YES NO

HEPATITIS …….. YES NO

AIDS OR OTHER IMMUNE DISORDER …….. YES NO

ASTHMA …….. YES NO

TUBERCULOSIS …… YES NO

DIABETES …… YES NO

EPILEPSY ……. YES NO

ANEMIA …… YES NO

VENERAL DISEASE …….. YES NO

CANCER …….. YES NO

IF YES, WHAT TYPE? _____

JOINT REPLACEMENT …… YES NO

IF YES, WHICH JOINT(S), WHEN, WHO PERFORMED THE SURGERY?

_____

HAVE YOU EXPERIENCED PROLONGED BLEEDING …… YES NO

HAVE YOU HAD AN UNUSUAL REACTION TO AN **ANESTHETIC** OR **DRUG** … YES NO

ARE YOU ALLERGIC TO **PENICILLIN, NOVACAINE,** OR **LATEX**…… YES NO

FEMALE PATIENTS: ARE YOU PREGNANT ……. YES NO

IF YES, WHAT IS THE DUE DATE? _____

IS THERE ANY OTHER INFORMATION THAT WOULD BE IMPORTANT RELATING TO YOUR MEDICAL OR DENTAL HEALTH? _____

DATE OF LAST DENTAL VISIT:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

SIGNATURE: _____

(Patient or Parent if minor)