Office Policies

Brandon K. Farrell, DDS
414 Chestnut Street (Suite 301)
Wilmington, NC 28403

Scheduling

- **Appointment Confirmation** – You will be prompted to confirm your appointment with our office in two ways. First, you will receive a postcard or email message from the office approximately 1 week before your appointment. Please give our office a call to confirm that you did receive the post card and will be present at your appointment. If we do not hear from you after we send the post card, we will call you approximately 24 hours prior to your scheduled appointment. If we leave a message with you, please call us back to confirm and keep your appointment. If we do not hear back from you or if you do not have a working number we will try and fill your appointment with another patient.

- **Timeliness** – Please make every effort to arrive at your appointment at least five minutes before the scheduled time. We make every effort to keep our schedule on time and begin your treatment at the scheduled time. If you arrive more than 15 minutes late for your appointment you may need to be rescheduled for a different day.

- **Rescheduling and Cancelling Appointments** – When rescheduling or cancelling an appointment, we require the courtesy of at least 24 hours notice.

- **Failure to Make Appointments without Notification** – In the unlikely event of two failures to make a scheduled appointment without notification, you may be dismissed from the practice.

- **After Hours Calls** – In the event of a true dental emergency, such as swelling, bleeding or trauma, please call our office and the voicemail will prompt you to call an after hours telephone number.

Patient Privacy

- Please read the accompanied document titled “Notice of Privacy Practices”.

Financial

- **Payment** – The patient’s portion which includes deductibles, co-pays, and/or a percentage of each procedure is due in full at the time of service. We accept cash, check, Visa, MasterCard, and Care Credit.

- **Insurance –** Please present your current insurance verification to the front desk representative every time you visit the office. Our office files all patient insurance claims with their respective insurance provider. However, filing insurance claims with the insurance provider is not a guarantee of payment. For uncovered services or fees, the patient (or their legal guardian) is ultimately responsible for all fees incurred. Also, for claims not paid within 60 days of our filing date, the patient becomes responsible for the balance due.

I verify that I have read, understand, and agree to all of the above policies.

Signed: _____

Date: _____

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Patient Information

Date _____

Name _____ Male Female
Last First M

Social Sec. # _____ Married Single Minor

Address _____
Street Apt. # City State ZIP

Birthdate _____ Telephone _____
MM DD YY Home Work Cell Email

Name of Employer _____ Address _____

If Full Time Student, School Name _____ Grade _____

Person Responsible for Account - Please circle one Patient Guardian Spouse Father Mother

Insurance Information Adults - Complete primary insured, Minor/Child - May need to complete both blocks for parent information, Dual Coverage also complete secondary insured.

Primary Insured

* if no insurance complete for responsible party

Last First M

Street City State ZIP

Home Work Cell Email

Birth Date (MM/DD/YY) Relationship to Patient

Employer Dental Ins. Co

SS# Subscriber # Group#

Secondary Insured

Last First M

Street City State ZIP

Home Work Cell Email

Birth Date (MM/DD/YY) Relationship to Patient

Employer Dental Ins. Co

SS# Subscriber # Group#

Emergency Contact _____

Name _____

Address _____

City/ST/ZIP _____

Telephone # _____

Method of Payment

Responsible party currently has an account with office.

Yes No

Form of Payment

Check Credit Card Cash

How did you find out about our office?

Insurance Website Yellow Pages Internet Marketing Packet Other_____

Referred by another patient, if so please indicate the patient's name. _____

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or health professional by any method, including electronic transfer.

X _____ _____ _____
Patient or Responsible Party Date State Driver's License #

BRUSH DENTAL CARE

Medical History

Patient Name_____ Date_____

Primary reason for dental appointment (circle): Examination Emergency Consultation

Dental History Circle

Do you have a specific dental problem? Describe _____	Yes No
Do you have dental examination on a routine basis? Last Visit Date _____	Yes No
Do you brush and floss on a routine basis?	Yes No
Do your gums ever bleed?	Yes No
Does food catch between your teeth? Any loose teeth?	Yes No
Do you ever have clicking, popping, or discomfort in the jaw joint? Do you grind your teeth?	Yes No
Have your past experiences in a dental office always been positive?	Yes No
Do you smoke or chew tobacco? Any sores or growths in your month? Discuss _____	Yes No

Name of previous dentist (optional): _____

Date of last full mouth x-rays? _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____	Yes No
Have you ever been hospitalized or had a major operation? Discuss _____	Yes No
Have you ever had a serious injury to your head or neck? Discuss _____	Yes No
Are you taking any medications, aspirin, vitamins, or drugs? What? _____	Yes No
Are you on a special diet? Discuss _____	Yes No
Are you allergic to any medications or substances? Please circle below	Yes No

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

Women (please circle): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate boxes.
* If yes to any of the starred conditions, please call prior to your appointment. Premedication may be required.

Heart Disease/Surgery*	Yes No	Excessive Bleeding	Yes No
Heart Murmur *	Yes No	Sickle Cell Disease	Yes No
Irregular Heart Beat	Yes No	Hemophilia (Bleeding Problem)	Yes No
Angina/Chest Pain	Yes No	Leukemia	Yes No
Heart Attack/Failure	Yes No	Recent Blood Transfusion	Yes No
Congenital Heart Disorder	Yes No	Swelling of Limbs	Yes No
Mitral Valve Prolapse *	Yes No	Lung Disease	Yes No
Scarlet Fever	Yes No	Breathing Problem	Yes No
Rheumatic Fever *	Yes No	Shortness of Breath	Yes No
Artificial Heart Valve *	Yes No	Frequent Cough	Yes No
Heart Pace Maker *	Yes No	Hay Fever	Yes No
Pulmonary Shunt	Yes No	Sinus Trouble	Yes No
High Blood Pressure	Yes No	Asthma	Yes No
Low Blood Pressure	Yes No	Bloody Sputum	Yes No
Bacterial Endocarditis	Yes No	Emphysema	Yes No
Unexplained Fever	Yes No	Tuberculosis	Yes No
Bruise Easily/Blood Disease	Yes No	Cancer	Yes No
Anemia	Yes No	X-Ray Treatments	Yes No
Chemotherapy	Yes No	Night Sweats	Yes No
Osteoporosis	Yes No	Yellow Jaundice	Yes No
Bisphosphonates	Yes No	Kidney Problems	Yes No
Osteonecrosis of Jaw	Yes No	Renal Dialysis	Yes No
Aredia IV	Yes No	Thyroid Disease	Yes No

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Zometa IV	Yes	No	Parathyroid Disease	Yes	No
Fosamax, Sctonel, Boniva	Yes	No	Arthritis/Gout	Yes	No
Stomach/Intestinal Disease	Yes	No	Pheumatism	Yes	No
Ulcers	Yes	No	Pain in Jaw Joints	Yes	No
Recent Weight Loss	Yes	No	Cortison Medicine	Yes	No
Frequent Diarrhea	Yes	No	Artificial Joint	Yes	No
Diabetes	Yes	No	Venereal Disease	Yes	No
Excessive Thirt	Yes	No	AIDS	Yes	No
Hypoglycemia	Yes	No	HIV Positive	Yes	No
Liver Disease	Yes	No	Genital Herpes	Yes	No
Hepatitis A (Infectious	Yes	No	Drug Addiction/Alcoholism	Yes	No
Hepatitis B or C	Yes	No	Tattoos/Body Piercing	Yes	No
Cold Sores	Yes	No	Nervousness	Yes	No
Fever Blisters	Yes	No	Psychiatric Care	Yes	No
Herpes	Yes	No	Alzheimer's Disease	Yes	No
Stroke	Yes	No	Allergies (Medicines)	Yes	No
Convulsions	Yes	No	Allergies (Pollen / Dust)	Yes	No
Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No
Fainting or Dizziness	Yes	No	Need Premedication?	Yes	No
Glaucoma	Yes	No	Ever taken fen-phen?*	Yes	No
Tumors or Growths	Yes	No			

Have you ever had any other serious illness not checked above? Please discuss below.

Do you wish to talk to the dentist privately about any problem? Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

x

Patient Signature (parent or guardian) Date

Reviewed by Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings

Medical Updates

I have read my Medical History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions		Patients Signature	Reviewed by Signature
		None		Dr.
		None		Dr.
		None		Dr.
		None		Dr.

BRUSH DENTAL CARE

NOTICE OF PRIVACY PRACTICES

Dr. Brandon Farrell DDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

NOTICE OF PRIVACY PRACTICES

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION - If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

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