

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School / College _____ City _____ State/Prov. _____ Full Time Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this Person Currently a Patient in our Office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

DOGWOOD DENTAL CARE
P O BOX 1029
1911 CONGRESS PARKWAY
ATHENS TN 37371-1029

Please indicate your payment choice (**Deposit required on all treatment**).

1. Pay in full at each visit (cash, Check, or Credit Card) _____
Card Name (Visa, MasterCard, Discover) _____
Account # _____
Expiration Date _____

2. Bill Insurance Co. and pay patient's portion. _____
Authorize Credit Card Payment on balance after insurance payment.
Card Name (Visa, MasterCard, Discover) _____
Account # _____
Expiration Date _____

3. Monthly Payment (Must sign **Truth-in-Lending** and/or complete **Credit Application and Qualify**) **AVAILABLE ON MAJOR TREATMENT**

I certify that the above information is correct. I agree to pay this account according to the policy of this office. I agree to pay a reasonable collection charge in the event of a default.

Signature _____ Date _____

**Authorization for Signature on File
Authorization of Payment**

I _____ hereby authorize the office of Dr. J.D. Kennedy, DDS, to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependants through my employment with _____.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of J.D. Kennedy, DDS.

This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as a original.

Today's Date

Signature of Patient

Expiration Date

Witnessed by

**DOGWOOD DENTAL CARE
J. DALE KENNEDY, D.D.S.**

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

FEDERAL AND STATE LAW REQUIRES US TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION. THAT LAW ALSO REQUIRES US 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 WE DESCRIBE IN THIS NOTICE WHILE IT IS IN EFFECT. THIS NOTICE TAKES EFFECT APRIL 14, 2003, 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 APPLICABLE LAW PERMITS THE CHANGES. 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 HEALTH CARE OPERATIONS. FOR EXAMPLE:

TREATMENT: WE MAY USE YOUR HEALTH INFORMATION FOR TREATMENT OR DISCLOSE IT TO A DENTIST, PHYSICIAN OR OTHER HEALTH CARE PROVIDER PROVIDING TREATMENT TO YOU.

PAYMENT: WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION TO OBTAIN PAYMENT FOR SERVICES WE PROVIDE TO YOU. WE MAY ALSO DISCLOSE YOUR HEALTH INFORMATION TO ANOTHER HEALTH CARE PROVIDER OR ENTITY THAT IS SUBJECT TO THE FEDERAL PRIVACY RULES FOR ITS PAYMENT ACTIVITIES.

HEALTH CARE OPERATIONS: WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR OUR HEALTH CARE OPERATIONS. HEALTH CARE OPERATIONS INCLUDE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, REVIEWING THE COMPETENCE OR QUALIFICATIONS OF HEALTH CARE PROFESSIONALS, EVALUATING PRACTITIONER AND PROVIDER PERFORMANCE, CONDUCTING TRAINING PROGRAMS, ACCREDITATION, AND CERTIFICATION, LICENSING OR CREDENTIALING ACTIVITIES. WE MAY DISCLOSE YOUR HEALTH INFORMATION TO ANOTHER HEALTH CARE PROVIDER OR ORGANIZATION THAT IS SUBJECT TO THE FEDERAL PRIVACY RULES AND THAT HAS A RELATIONSHIP WITH YOU TO SUPPORT SOME OF THEIR HEALTH CARE OPERATIONS. WE MAY DISCLOSE YOUR INFORMATION TO HELP THESE ORGANIZATIONS CONDUCT QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, REVIEW THE COMPETENCE OR QUALIFICATIONS OF HEALTH CARE PROFESSIONALS, OR DETECT OR PREVENT HEALTH CARE FRAUD AND ABUSE.

ON YOUR AUTHORIZATION: YOU MAY GIVE WRITTEN AUTHORIZATIONS TO USE YOUR HEALTH INFORMATION OR DISCLOSE IT TO ANYONE FOR ANY PURPOSE. IF YOU GIVE US AN AUTHORIZATION, YOU MAY REVOKE IT IN WRITING ANY TIME. YOUR REVOCATION WILL NOT AFFECT ANY USES 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 TO THOSE DESCRIBED IN THIS NOTICE.

TO YOUR FAMILY AND FRIENDS: WE MAY DISCLOSE YOUR HEALTH INFORMATION TO A FAMILY MEMBER, FRIEND OR OTHER PERSON TO THE EXTENT NECESSARY TO HELP WITH YOUR HEALTH CARE OR WITH PAYMENT FOR YOUR HEALTH CARE. BEFORE WE DISCLOSE YOUR HEALTH INFORMATION TO THESE PEOPLE, WE WILL PROVIDE YOU WITH AN OPPORTUNITY TO OBJECT TO OUR USE OF DISCLOSURE. IF YOU ARE NOT PRESENT, OR IN THE EVENT OF YOUR INCAPACITY OR AN EMERGENCY, WE WILL DISCLOSE YOUR MEDICAL INFORMATION BASED OF OUR PROFESSIONAL JUDGMENT OF WHETHER THE DISCLOSURE WOULD BE IN YOUR BEST INTEREST. WE MAY 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. WE MAY USE OR DISCLOSE INFORMATION ABOUT YOU TO NOTIFY OR ASSIST IN NOTIFYING A PERSON INVOLVED IN YOUR CARE, OF YOUR LOCATION AND GENERAL CONDITION.

APPOINTMENT REMINDERS: WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION TO PROVIDE YOU WITH APPOINTMENT REMINDERS (SUCH AS VOICEMAIL MESSAGES, POSTCARDS OR LETTERS).

DISASTER RELIEF: WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION TO A PUBLIC OR PRIVATE ENTITY AUTHORIZED BY LAW OR BY ITS CHARTER TO ASSIST IN DISASTER RELIEF EFFORT.

**DOGWOOD DENTAL CARE
J. DALE KENNEDY, D.D.S.**

**INSTRUCTIONS FOR OUR NOTICE OF PRIVACY
PRACTICES**

PURPOSE: THIS NOTICE OF PRIVACY PRACTICES PRESENTS THE INFORMATION THAT THE HIPAA PRIVACY RULES REQUIRE US TO GIVE OUR PATIENTS REGARDING OUR PRIVACY PRACTICES.

WE MUST PROVIDE THIS NOTICE TO EACH PATIENT NO LATER THAN THE DATE OF OUR FIRST SERVICE DELIVERY TO THE PATIENT, AFTER APRIL 14, 2003. WE MUST ALSO HAVE THE NOTICE AVAILABLE AT THE OFFICE FOR PATIENTS TO REQUEST TO TAKE WITH THEM, WE MUST POST THE NOTICE IN OUR OFFICE IN A CLEAR AND PROMINENT LOCATION WHERE IT IS REASONABLE TO EXPECT ANY PATIENTS SEEKING SERVICE FROM US TO BE ABLE TO READ THE NOTICE. WHENEVER WE REVISE THE NOTICE, WE MUST MAKE THE NOTICE AVAILABLE UPON REQUEST ON OR AFTER THE EFFECTIVE DATE OF THE REVISION IN A MANNER CONSISTENT WITH THE ABOVE INSTRUCTIONS. THEREAFTER, WE MUST DISTRIBUTE THE NOTICE TO EACH NEW PATIENT AT THE TIME OF SERVICE DELIVERY AND TO ANY PERSON REQUESTING A NOTICE. WE MUST ALSO POST THE REVISED NOTICE IN OUR OFFICE AS DISCUSSED ABOVE.

WE MUST MAKE A GOOD FAITH EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE FROM EACH INDIVIDUAL WITH WHOM WE HAVE A DIRECT TREATMENT RELATIONSHIP AND TO WHOM WE PROVIDE THIS NOTICE, EXCEPT IN EMERGENCY SITUATIONS. IF WE DO NOT OBTAIN THE ACKNOWLEDGEMENT, WE MUST DOCUMENT OUR EFFORTS AND REASON WE DID NOT OBTAIN THE ACKNOWLEDGEMENT. THE LAST PAGE OF THE NOTICE IS A WRITTEN ACKNOWLEDGEMENT THAT EACH PATIENT SHOULD SIGN. WE SHOULD KEEP THE ACKNOWLEDGEMENT IN THE PATIENT'S DENTAL RECORD.

**DOGWOOD DENTAL CARE
J. DALE KENNEDY, D.D.S.**

SECTION A: THE PATIENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____ E-MAIL: _____

BIRTHDATE: _____ SOCIAL SECURITY NUMBER _____

SECTION B: ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE.

I, _____, ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES FROM THE ABOVE-NAMED PRACTICE.

SIGNATURE: _____ DATE: _____

IF A PERSONAL REPRESENTATIVE SIGNS THIS AUTHORIZATION ON BEHALF OF THE INDIVIDUAL, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME: _____

RELATIONSHIP TO INDIVIDUAL: _____

SECTION C: GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT.

DESCRIBE YOUR GOOD FAITH EFFORT TO OBTAIN THE INDIVIDUAL'S SIGNATURE ON THIS FORM: _____

DESCRIBE THE REASON WHY THE INDIVIDUAL WOULD NOT SIGN THIS FORM: _____

SIGNATURE

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT.

SIGNATURE _____ DATE: _____

PRINT NAME: _____ TITLE: _____

KEEP THIS ACKNOWLEDGEMENT OF RECEIPT IN THE INDIVIDUAL'S RECORDS.
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE