MULLER
FAMILY DENTISTRY

Robert Muller, D.D.S.

We are please to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you in maintaining your dental health.

Name_____ Address_____

City_____ State_____ Zip_____ Home Phone_____

Work Phone_____ Cell Phone_____ Sex(Male/Female)____

Marital Status_____ Date of Birth_____ Social Security#_____

Patients Employer/School_____ Occupation_____

Whom May we thank for referring you?_____
Reason for today's visit?_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy

OTHER ALLERGIES:
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- List ALL medications you are currently taking: _____
- Do you have any health problems that need further clarification like metal in the body? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

In case of Emergency, notify: _____ Phone #: _____

Pharmacy Name: _____ Phone #:_____

Former Dentist: _____ Phone #: _____
Date of last Dental Care: _____ Date of last X-Rays_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Carrier Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

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

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

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

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

MULLER
FAMILY DENTISTRY

Robert Muller, D.D.S.

1301 N.W. 63rd Street ❖ Lawton, Oklahoma 73505 ❖ (580) 536-7172

Our Financial Policy

We would like to thank you for choosing us as your Dental Care Provider. We are committed to your treatment being successful and addressing any concerns you might have. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to treatment.

** ALL patients must complete our "Patient Information Form" before seeing the Doctor.
** If you will not be filing insurance, FULL payment is due at the time of service.
** We accept Cash, Visa, MasterCard and CareCredit.
** We do offer extended payment plans with prior approval

Regarding Insurance:
As a courtesy to you, we file your insurance for you. Please keep in mind that your insurance will cover a portion of you treatment, however any portion not covered by your insurance is your responsibility and is required to be paid in full at the time of service. This amount may be 20-50%, depending on the service provided.

IMPORTANT NOTICE: I understand I am fully responsible for any charges remaining on my account due to unpaid insurance claims after 60 days from the original date of service.

DISCOUNT: You will receive a 5% discount if paid in full by cash or check the same day of service. If you have insurance and you wish to take advantage of our discount, you must pay your balance in full the same day services are rendered. Once your insurance is received, we will reimburse you the amount that the insurance paid, not to exceed the discounted fee.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above policy.

Patient or Responsible Party_____Date_____

Robert Muller, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name:_____

Address:_____

Telephone:_____ Social Security#_____

Section B: To the Patient- Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practice: 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, or other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully 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 may maintain. You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person: Robert Muller, D.D.S., P.C.
P.O. Box 6158
Lawton, Oklahoma 73506

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 Consent before we received your revocation, and that we may decline to treat you if you revoke this consent.

Signature:

I,_____, have had full opportunity to read and consider the contents of this Consent for and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to you and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operation.

Signature_____ Date:_____

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

Personal Representative's Name:_____

Relationship to Patient: _____

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date:_____

You are entitled to a copy of this Consent after you sign it.

Robert Muller, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

_____, **have received a copy of this office's Notice of Privacy Practice.**

_____

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)

_____

_____

_____

_____

_____

_____

_____

Robert Muller, 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 is important to us.

Our Legal Duty:

We are required by applicable federal and state laws to maintain the privacy of you health information. We are also required to give you this Notice of 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 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 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 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 us 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 Operation: 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 professional evaluation 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 written authorization to use your health information 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 the 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 identification or locating) a family member, your personal representative or another person responsible for your care, or 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 and our experience with common practice to make reasonable inferences on 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 protecting 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 voice mail 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 copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You may request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information posted at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time for each page, $20.00 per hour for staff time to locate and copy your health information, and postage is you want the copies mailed. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. We will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instance in which we or our business associates disclose information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last date, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a cost-based fee for responding to these additional requests.

Restricition: You have the right to request that we place additional restriction on our use or disclosure of your health. We are not required to agree to theses 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 means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means and provide satisfactory explanation how payments will be handles 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, and 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 it in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions and 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 information or in responses to a request you made to amend or restrict the use and disclosure of your health information, communicate with you by alternative means or at alternative locations, you may complain to us using the contact information 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 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 the U.S. Department of Health and Human Services.

Contact Officer:

Robert Muller, D.D.S, P.C.
P.O. Box 6158
Lawton, Ok. 73506
(580) 536-7172