BAY ORAL & FACIAL SURGERY

ATTENTION

Must bring to your appointment:

- Please have x-ray and referral emailed over from your General Dentist or bring with you to your appointment.
  Email address is: office@bayoralfs.com

- Please have all new patient paperwork completed upon arrival. (Please have a list of any medications that you are taking, this includes over the counter medications)

Please note that Dr. Heitzmann is not in network with any insurance companies. However, as a courtesy for our patients we will file your insurance. Based on your coverage, your insurance company will reimburse you directly. If you are a Medicaid or Medicare beneficiary, you are responsible for the entire cost of your care (Medicaid and Medicare will not reimburse directly).

Please let us know if you have any questions. 850-271-8001

Patient's Name:
_____ Date: _____

Are you in good health? Yes No
Are you currently under a physician's care? Yes No Physician's Name: _____
Are you taking any medication? Include non-prescription and herbal medications.

_____

Have you had any serious illnesses, Surgeries, or hospitalizations? _____

_____
Are you allergic to or had any reaction to:

Local Anesthetic (novacaine, etc.)_____ Yes No
Antibiotics (Penicillin, etc.)_____ Yes No
Pain Medicine _____ Yes No
Sedatives _____ Yes No
Latex/rubber products _____ Yes No

List and **ALLERGIES**: _____
Have you had any adverse effects from dental treatment? _____ Yes No
Do you smoke or chew tobacco? _____ Yes No
Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders? _____ Yes No

	YES	NO			YES	NO
HEART DISEASE				**LIVER DISEASE**		
RHEUMATIC FEVER				**HEPATITIS (Yellow Jaundice)**		
RHEUMATIC HEART DISEASE				**CIRRHOSIS**		
HEART MURMUR				**DIABETES (Sugar)**		
MITRAL VALUE PROLAPSE				**DO YOU TAKE INSULIN?**		
HIGH BLOOD PRESSURE				**THYROID DISEASE**		
ANGINA				**GLAUCOMA**		
HEART ATTACK (Coronary)				**SEIZURE DISORDER**		
HEART DEFECTS				**ANEMIA**		
STROKE				**AIDS OR HIV POSITIVE**		
ABNORMAL EKG				**SICKLE CELL ANEMIA OR TRAIT**		
HEART SURGERY				**TUMOR OR CANCER**		
PACEMAKER				**RADIATION THERAPY**		
LUNG DISEASE				**HIP JOINT SURGERY**		
BRONCHITIS				**BLEEDING PROBLEMS**		
ASTHMA				**SLEEP APNEA/ Snoring, etc.**		
PREGNANT (How many weeks?)				**BIRTHCONTROL**		
HORMONE REPLACEMENTS				**OTHER**		

I UNDERSTAND THE IMPORTANCE OF DISCLOSING ALL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY AND ANY QUESTIONS WITH DR. HEITZMANN AT ANY TIME DURING MY TREATMENT.

_____ _____

SIGNATURE OF PATIENT/ OR PERSON COMPLETING HEALTH HISTORY FORM **DATE** **DR'S INITIALS**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 01/01/2023 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $____for each page and the staff time charged will be $_____per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $_____for each page and the staff time charged will be $_____ per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US:

Practice Name: Bay Oral & Facial Surgery Privacy Officer: Dr. Scott Heitzmann

Telephone: 850-271-8001 Fax: 850-277-0390

Email: office@bayoralfs.com

Address: 651 Grand Panama Blvd. Suite 106 Panama City Beach, FL 32407

Patient Information Sheet

Patient's Name: _____ Date: _____
Last First Middle Initial

Mailing Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Alt. Phone#: _____

Date of Birth: _____ SSN: _____ Age: _____

Person Financially Responsible: _____Relationship: _____

SSN: _____ DOB: _____ Phone #: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

IN CASE OF EMERGENCY NOTIFY: _____

Phone #: _____ Relationship: _____

Referring Dentist: _____ Primary Care Doctor: _____

Other Dr's you visit: _____

Dental Insurance Co: _____ Policy Holder: _____

ID #: _____ Group #: _____ Policy Holder's DOB: _____

Relationship to patient: _____ Policy Holder's Employer: _____

Medical Insurance Co.: _____ Policy Holder: _____

ID #: _____ Group #: _____ Policy Holder's DOB: _____

Relationship to patient: _____ Policy Holder's Employer: _____

I certify that all statements above are true and correct, and I authorize the release of medical information necessary to access my claim:

I authorize payment of Insurance Benefits to Bay Oral & Facial Surgery for services described on claim:

Signed: _____

Signed: _____

Date: _____

I have read or been offered a copy of the HIPPA Compliance documentation Signed: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice.

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

_____

Please print your name

_____

Signature

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names and the relationship to you of the individual(s) you authorize our office to discuss your care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

_____ The patient refused to sign

_____ Due to an emergency, it was not possible to obtain an acknowledgement

_____ We were not able to communicate with the patient

_____ Other (Please provide specific details)

_____

_____

_____ _____

Employee Signature Date

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please let us know the best way to contact you:

_____Home Phone, is it ok to leave a message----------_____ Yes _____ No

_____Cell Phone, is it ok to leave a message---------- _____ Yes _____ No

_____Work Phone, is it ok to leave a message---------- _____ Yes _____ No

I allow **BAY ORAL & FACIAL SURGERY** to disclose and receive my clinical information to/from (check all that apply and print contact person's name)

_____ _____
Name Relationship to the patient

_____ _____
Name Relationship to the patient

_____ _____
Name Relationship to the patient

_____

_____
Doctor's, Dentist, etc. (Please list phone numbers if you have them)

_____ _____
Print patient's name Date

_____ _____
Patient Signature Date

_____
Authorized person Signature (if pt is a minor)

PATIENT FINANCIAL AGREEMENT & RELEASE OF INFORMATION

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. **PAYMENT** *Payment of any unmet deductible, co-insurance, co-payment, and any charges no covered by insurance is expected at the time of your visit. We accept cash, check, and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service.

2. **INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE**

* It is your responsibility to confirm which treatments or procedures are covered and/or paid by insurance (including, but not limited to, any applicable exclusion, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
* As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. In order to bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
* We can only approximate the percentage covered by each plan. Payment of the ESTIMATED portion as well as your co-payment is due at time of service.
* Any estimate of insurance coverage may differ from what your insurance carrier ultimately pays. You will be responsible for any charge that insurance determines to be not covered.
* NOTE: If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service.
* As the parent or guardian accompanying a minor, you are financially responsible for all charges, whether or not paid by insurance.
* In situations of divorce, separation, court orders, etc., the adult who signs in a minor child on the day of treatment accepts financial responsibility for payment.
*Non-covered procedures will not be filed to insurance.
* Medicare does not cover in-office general anesthesia or dental related procedures including extractions.
*Adults 21 years of age and older are not eligible for dental coverage through Medicaid.
* Private pay/uninsured patients must pay in full at time of service

3. **BILLING AND COLLECTION**

* Returned checks will be subject to a fee of up to $30.00, except where prohibited by law.
* Payment is due as stated on any billing statement mailed, emailed, or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past due.
* Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
* Past due accounts may be placed with a collection agency o attorney for collection.

In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees (either 33.33% or the amount due or the maximum amount allowed by applicable law), reasonable attorney's fees and expenses, collection expenses, and court cost. If your account is turned over to collections, you hereby accept any such fees and costs as a legal and lawful debt and agree to pay said fees, including any and all resulting fees and costs. You hereby waive your right of exemption under any applicable laws.

* If your account is turned over for collections, you will no longer be able to receive services from the practice until your delinquency is cured.

4. **CONSENT TO CONTACT** The practice and anyone contacting you on our behalf may contact you for any purpose and in any manner permitted by law. You also expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We and/or anyone contacting you on our behalf may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the practice, and anyone contacting you on our behalf, may communicate with you in any manner, including through the use of an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

5. **CANCELLATIONS** We require a 48 hr notice to reschedule or cancel your surgery appt. If you fail to do so, you will be required to pay the surgery total upfront before you are rescheduled.

I have read the financial policies above, and my signature below indicated my agreement to these policies and acceptance of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any services provided to me, I assume financial responsibility and will pay all such charges in full.

I hereby authorize the practice to furnish information to insurance carrier concerning my illness and treatments, and I hereby assign to the practice all insurance benefits otherwise payable to me for the practice's services.

_____ _____

Patient Name Patient DOB

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Printed name of Responsible Party (if applicable) Relationship to Patient (if applicable)