PATIENT REGISTRATION

PLEASE PRINT

NAME _____ AGE _____ M / F DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SOC. SEC _____ OCCUPATION _____

EMPLOYER NAME _____ EMPLOYER PHONE _____

STUDENT SCHOOL (IF FULLY TIME) _____

EMERGENCY CONTACT _____ PHONE _____

FAMILY PHYSICIAN _____ PHONE NUMBER _____

REFERRING DENTIST/ADDRESS _____

PRIMARY INSURANCE HOLDER AND/OR PERSON RESPONSIBLE FOR ACCOUNT

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ OCCUPATION _____

SOC. SEC _____ DATE OF BIRTH _____

EMPLOYER _____ EMPLOYER PHONE _____

INSURANCE INFORMATION (THAT WILL COVER PROCEDURE)

MEDICAL	DENTAL
INSURANCE NAME _____	INSURANCE NAME _____
ADDRESS _____	ADDRESS _____
ID # _____	ID # _____
GROUP # _____	GROUP # _____

SECONDARY INSURANCE (THAT WILL COVER PROCEDURE)

NAME _____ ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____ SOC SEC _____

MEDICAL	DENTAL
INSURANCE NAME _____	INSURANCE NAME _____
ADDRESS _____	ADDRESS _____
ID # _____	ID # _____
GROUP # _____	GROUP # _____

FINANCIAL POLICY
THE FOLLOWING IS OUR OFFICE POLICY
REGARDING PAYMENT FOR SERVICES RENDERED

(WITH INSURANCE) A payment of $100.00 for consultation, x-ray, and single tooth extraction with local anesthesia is required the day of surgery. For surgical procedures involving general anesthesia, multiple extractions, or any procedures that are scheduled for 1 hour or longer, any amount exceeding your insurance coverage must be paid at the time your appointment is scheduled. Please present your insurance form or card, with the mailing address, to be copied for our records. It is your responsibility to obtain your insurance provider address and/or information, and to know if your insurance provider will pay for the procedure. If your insurance provider will not pay for the procedure, you are responsible for the outstanding balance.

We will submit your claim to your insurance provider on the day of surgery. **If your insurance provider does not provide us with an explanation of the benefits (EOB) within 30 days, you are responsible for all follow-up calls to the insurance provider.** If your insurance provider pays you directly, and you have an outstanding balance, it is your responsibility to forward the payment to our office. After we receive the payment from your primary insurance provider, we will resubmit the claim to your secondary insurance provider.

You are responsible for any outstanding balance after your insurance provider pays. After 30 days, interest will accrue on your account at 1.5% per month (18% per year) until the balance is paid in full. Should a negative balance result after your insurance provider has paid for a procedure, we will reimburse you.

(NO INSURANCE) Consultations, x-rays, single tooth extractions with local anesthesia, and surgical procedures with local anesthesia or general anesthesia must be paid in full at the time of service. **For surgical procedures involving general anesthesia, multiple extractions, or any procedures that are scheduled for 1 hour or longer, payment for the procedure must be made in full at the time your appointment is scheduled.** After 30 days, interest will accrue on your account at 1.5% per month (18% per year) until the balance is paid in full.

We accept Visa, MasterCard, and Discover. Financing is available through Care Credit.
A fee of $40.00 will be charged for all returned checks.

If you are in a divorce situation, it is your responsibility to ensure that the responsible party for the account is aware of the total bill and our financial policy.

Thank you for selecting Drs. Mascaro and Choi. If you have any questions regarding treatment, fees, or services rendered, please discuss them with us. We will make every effort to answer your questions and provide the best care possible.

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

_____ _____

Signature Patient/Responsible Party Date

_____ _____

Print Patient/Responsible Party Relationship to Patient

Great Lakes Jaw & Implant Surgery Center
John R. Mascaro, D.M.D., M.D.
Carl R. Choi, D.D.S., M.D.
4230 State Route 306, Suite 350
Willoughby, OH 44094
(440) 946-2247

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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)

_____

_____

_____

Great Lakes Jaw & Implant Surgery Center
John R. Mascaro, D.M.D., M.D. • Carl R. Choi, D.D.S., M.D.
4230 State Route 306 #350, Willoughby, Ohio 44094
440-946-2247

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/13 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, and to make new Notice provisions effective for all protected health care information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in You Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person had the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We maty use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person or a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a suboena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Adminstrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researches when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to indetify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable laws. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.