Jeffrey M. Kadair, D.D.S.
6721 Government St. Ste. A
Baton Rouge, LA 70806
(225) 925-8210

Medication Specific Questionnaire

Are you currently taking or have you ever taken any of the following medications:

Trade Name	Generic Name	Yes	No
Actonel	risedronate		
Aredia	pamidronate		
Bonefos	clodronate		
Boniva	ibandronate		
Didronel	etidronate		
Fosamax	alendronate		
Ostac	clodronate		
Skelid	tiuldronate		
Zometa	zoledronic acid		

These medications have been linked to possible abnormal bone healing after oral surgery and may alter treatment recommendations.

Patient Signature ______________________ Date ______________

FINANCIAL POLICY

Consent for Service

Our office strives to provide the highest quality of dental care at affordable prices. Our patients receive prompt attention and excellent service. We believe that a satisfied patient returns for additional services, refers others to practice and pays their bill promptly. To help maintain a good relationship with our patients, this office has adopted a written financial policy. The purpose of this policy is to eliminate confuse or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

For those with insurance benefits, we are happy to bill your insurance as a courtesy to you. **Please note that your insurance contract exists solely between you and your insurance carrier. We will file your insurance claim, but we cannot guarantee benefits. Your insurance plan is a benefit to you to help offset the cost of necessary dental care. Ultimately, you are responsible for the entire cost of your dental treatment.** I authorize release of any information to third party payers and other health practitioners. I also assign all insurance benefits to the Doctor.

I authorize the Doctor to take x-rays, study models, photographs, or any other diagnosed aids deemed appropriate by Doctor to make a through diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. Additionally, my intra oral pictures and radiographs may be used for patient education.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services are performed**, including the estimated portion of the amount that insurance does not cover.** Our office accepts the following payment options: Cash, Check, Discover, American Express, MasterCard and VISA.

When the patient's portion cannot be paid at the time of service and payment arrangements extend beyond 60 days, an interest rate of 18% per a year will be charged on all outstanding balances. A credit report may be generated on established patients, prior to extending payment arrangements. Payment history with our office will be taken into consideration when establishing payment arrangements.

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.

A statement of services rendered will be mailed to you at the end of the month. Receipt of payment is expected by the 10th of the month. If payment is not received a late charge of $20.00 will be assessed and will appear on the next statement.

A $25.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time. However, if the funds are still insufficient, we will not accept payments by check from you in the future.

There will be no charge for a canceled appointment with 48 hours' notice. This allows our office to fill the reserved time slot from our list of patients who are able to come on short notice. Broken appointments with less than 48 hours' notice will be charged a $50.00 fee.

Delinquent accounts may be sent to a collection agency.

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 and payments.

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

Printed Name of Patient: ______________________________

Signature of Patient, Parent or Guardian: ______________________________

Relationship to Patient: ______________________________

Date: ____________________

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective of **JANUARY, 2009** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, (1-877-696-6775) about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement to this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason:

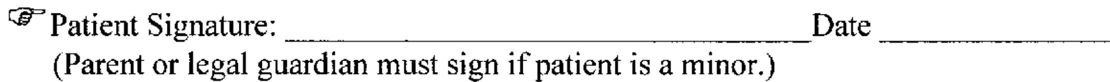
AUTHORIZATION TO RELEASE DENTAL RECORDS

I hereby authorize Dr. ______________________________ to release a photocopy of my dental treatment records and originals or duplicates of any current x-rays along with my treatment plans to the dental office of:

Jeffrey M. Kadair, D.D.S.
6721 Government St., Ste. A
Baton Rouge, LA 70806
Ph 225.925.8210
Fax 225.926.2896
jeffreykadair@brdentalcare.com

Patient's Name: ____

Date of Birth: _______/_______/________



☞ Patient Signature: _________________________________Date _______________
(Parent or legal guardian must sign if patient is a minor.)

FOR OFFICE USE ONLY

Date Request Sent: __________________________

Date Request Received: ______________________

Date Records Sent: __________________________