



SoCal Perio Implants

SOCAL PERIO
IMPLANTS

Nicholas Caplanis D.M.D., M.S., Giuseppe Carvelli D.M.D., M.S., Kian Kar D.D.S., M.S., Iman Madi D.M.D., M.S.

We realize that it is a contradiction to politely say "Welcome" and to immediately request that you complete these forms in the same sentence. However, it is vital that we obtain accurate, pertinent information in order to render the best possible treatment. Therefore, we must ask for your indulgence and request the inevitable. Please complete the following 4 forms. All information will be kept completely confidential. By the way, this is not an examination, and no grade will be given, so if you have any questions or would like assistance, please ask. Thank-you and welcome to our office!

I. Personal Information

Last Name: _____ First Name: _____ Nickname: _____

Middle Name: _____ Salutation: Mr. Mrs. Ms. Dr.

Home Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Email: _____ Drivers Lic. # _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Birth Date: _____ Age: _____

Spouse: _____ Spouse Employer: _____

Who may we thank for this referral? _____

Person Responsible For This Account (If patient is a minor or adult dependent)

Responsible Party: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

In the event of an Emergency, who should we contact?

Emergency Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Dental Insurance Information Do you have dental insurance coverage? Yes No

Primary Insurance: _____ Group# / Cert.#: _____ Employer: _____

Name of Policy Holder: _____ Birthdate: _____ SS#: _____

Necessary for claim submission

Secondary Insurance: _____ Group# / Cert.#: _____ Employer: _____

Name of Policy Holder: _____ Birth Date: _____ SS#: _____

Necessary for claim submission

I Certify that the above given information is true and accurate to the best of my knowledge.



Signature of Patient, Parent, or Guardian

Date



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14. Why are you now seeking Dental Treatment? Explain _____

- 15. Did your Dentist ask you to see us?.....Yes No
16. Has any Dentist ever suggested that you see a Periodontist?.....Yes No
17. Do you feel you know and understand what causes Periodontal Disease.....Yes No
18. Has a dentist ever told you that you will lose all your teeth someday.....Yes No
19. Do you believe you will lose all or most of your teeth someday.....Yes No
20. Do you believe that tooth loss is preventable or treatable?.....Yes No
21. Are you greatly concerned about losing your teeth and/or facial bone structure?.....Yes No
22. Do you visit your dentist regularly?.....Yes No
23. Do your gums bleed or feel sore?.....Yes No
24. Do you feel you have constant bad breath?.....Yes No
25. Do any of your teeth feel loose?.....Yes No
26. Are any of your teeth sensitive to hot, cold, sweets, or biting?.....Yes No
27. Have you noticed a change in your bite or shifting or teeth recently?.....Yes No
28. Do you feel that dentures are an adequate replacement for natural teeth?.....Yes No
29. When was the last time your teeth were cleaned or scaled?
30. Do your jaws pop or click or do you have difficulty opening or closing your jaw?.....Yes No
31. Have you ever had braces or orthodontic treatment?.....Yes No
32. Do you have a tremendous fear or become overly anxious when seeing a dentist?.....Yes No
33. Have you ever had a bad or traumatic experience in a dental office?.....Yes No
If so, explain _____

I certify that I have read and understood the two pages Medical / Dental History Forms above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my Doctor, or any other member of the staff, responsible for any errors or omissions that I have made in the completion of these forms.

X _____ Date
Signature of Patient, Parent, or Guardian

Medical History Updates:

Table with 4 columns: Date, Please Note Any Changes in Your Medical History since you last filled out these forms, Patient Signature, Doctors Review. Includes multiple rows for data entry.

For Completion by the Doctor

Patient management considerations and comments if any:

_____ Date
Doctor Signature

IV. Financial Policies

PAYMENTS

- We accept Cash, Checks and Credit Cards
- We offer third party financing through CareCredit® and Lending Club®
- Payment in full is required on the day of service unless prior arrangements are made
- We are in network providers for Delta Dental Premier and out of network for all other PPO's
- We do not accept HMO's

INSURANCE POLICY

Our insurance coordinator will assist patients in obtaining their entitled insurance benefits for all services rendered. A formal request to our Insurance Coordinator is required if pre-authorization of benefits is needed prior to scheduling for a procedure. Pre-authorization can take anywhere between 2-6 weeks depending on the carrier. Third party payers (insurance carriers) may pay less than the billed fees. Therefore, all fees incurred are ultimately patient responsibility regardless of insurance benefits.

DELTA DENTAL PREMIER INSURANCE

- Diagnostic service (i.e. examinations and radiographs) fees will be billed and collected from Delta. Any unpaid balance is the patient's responsibility and will be billed directly to the patient.
- Therapeutic service (i.e. surgeries) fees require prior pre-authorization. The patient portion of the fee is required in full on the day of service. The insurance portion will be billed and collected from Delta.

PPO INSURANCE

- Diagnostic service (i.e. examinations and radiographs) payments are required in full on the day of service.
- Therapeutic service (i.e. surgeries) payments are required in full on the day of service unless pre-authorization was obtained in which case only the patient portion of the fee is required on the day of the procedure and the insurance portion will be billed and collected from the carrier.
- A 5% discount is extended for all non-delta PPO insurance patients, with payments made with cash or check on the day of service for all surgeries.

UNINSURED PATIENTS

- Payments are required in full on the day of service unless prior arrangements are made.
- A 5% discount is extended for all uninsured patients, with payments made with cash or check on the day of service for all surgeries.



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FINANCING

Three financing options are available for any amount over \$1,000.

- In-Office Financing – 50% of the fee is required on the day of service with the remaining balance paid in two equal installments over the following 2 months. A valid credit card or postdated check is required.
- Financing through CARECREDIT® or LENDING CLUB® - Interest free plans available up to 24 months. Interest plans available up to 60 months. See our financial coordinator for additional information.

LATE CHARGES

A late charge of 1.5% on any unpaid and owed balance past 90 days will be assessed to your account unless prior financial arrangements are made with the office manager. Failure to keep your account current may prevent delivery of additional dental services, except in cases of emergencies.

BROKEN / MISSING APPOINTMENTS

Treatment time is specifically reserved for each individual patient. In consideration for all our patients needing appointments, we request AT LEAST 48 HOURS NOTICE if you are unable to keep your appointment for any reason. A missed appointment charge may be assessed to your account after the second broken or missed appointment. If three appointments are missed or broken, partial payment for service will be required prior to rescheduling the appointment.

1. I understand the office policy regarding financial arrangements, that payment is required at the time of service, that this policy applies regardless of insurance coverage and that I am ultimately financially responsible for all fees incurred by me or my dependents.

2. I understand and agree that if I fail to pay any outstanding balance within ninety (90) days, that my account may, without further notification, be referred for collection; I further agree to pay all reasonable costs incurred for this collection including interest, collection agency costs and/or attorney fees.

3. I authorize the release of all medical / dental records regarding all treatments and charges rendered to me or my dependent, to third party payers as needed to process payments.

4. I authorize payment of benefits directly to this office from third party payers if applicable.

X _____
Signature of Patient, Parent, or Guardian

Date

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy?

Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns,

associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.



Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the

restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Acknowledgment

Patient Name(s): _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Effective Date: _____