Patient Information

Name_____Soc. Sec. #_____
Last Name First Name Middle Initial

Address_____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Sex ___M ___ F Birthdate _____ Single___ Married ___ Widowed ___ Separated ___ Divorced ___

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone _____

Whom may we thank for referring you?_____

Notify in case of emergency _____ Phone _____

Primary Dental Insurance Information

Person Responsible for Account_____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient)_____ Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by_____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company_____ Phone _____

Insurance Co Address_____ City _____ State _____ Zip_____

Group # _____ Subscriber # _____

Name of other dependents under this plan_____

Additional Dental Insurance

Is patient covered by additional dental insurance? ___ Yes ___ No

Subscriber Name_____ Relation to Patient _____

Subscriber Birthdate _____ Subscriber Soc. Sec. # _____

Address (if different from patient)_____ Home Phone _____

City _____ State _____ Zip _____

Subscriber Employed by_____ Business Phone_____

Insurance Company_____ Phone_____

Insurance Co. Address_____ City_____ State_____Zip_____

Group # _____ Subscriber # _____

Name of other dependents under this plan_____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Date of last dental care _____ Date of last x-rays _____

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Check if you have had problems with any of the following:

___ Bad breath
___ Bleeding gums
___ Clicking or popping jaw
___ Food collection between teeth
___ Grinding or clenching teeth
___ Loose teeth or broken fillings
___ Peridontal treatment
___ Sensitivity to cold
___ Sensitivity to hot
___ Sensitivity to sweets
___ Sensitivity when biting
___ Sores or growths in mouth

Medical History

Physician's name _____ Phone _____

Do you have any current health problems? ___ Yes ___ No

Are you under a physician's care now? ___ Yes ___ No For what?_____

Check if you have had any of the following:

___ Anemia
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joints
___ Asthma
___ Bisphosphorate Therapy
___ Blood Disease
___ Cancer
___ Diabetes
___ Dizziness
___ Drug Addiction
___ Epilepsy or Seizures
___ Excessive Bleeding (due to extraction, etc.)
___ Fainting
___ Glaucoma
___ Head Injuries
___ Heart Disease
___ Heart Murmur
___ Hepatitis
___ High Blood Pressure
___ Infectious Disease/HIV/Aids
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Mental Disorders
___ Mitral Valve Prolapse
___ Nervous Disorders
___ Pacemaker
___ Radiation Treatment
___ Respiratory Problems
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Sinus Problems
___ Stomach Problems
___ Stroke
___ Swollen feet/ankles
___ Thyroid Problems
___ Tobacco Use
___ Tuberculosis
___ Tumors
___ Ulcers
___ Venereal Disease (Syphilis, Gonorrhea, etc.)
___ Other _____

Women: Are you pregnant? ___ Yes ___ No Nursing? ____ Yes ___ No Taking birth control pills? ___ Yes ___ No

Are you allergic to or have you reacted adversely to any of the following medications?

___ Aspirin ___ Codeine ___ Erythromycin ___ Latex (balloons, gloves, etc.)
___ Metals ___ Nitrous Oxide ___ Penicillin ___ Sulfa ___ Other_____

List medications you are currently taking, if any:

_____ _____ _____ _____ _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date _____

ALBANY COUNTY FAMILY DENTISTRY
BYRON W. KILLPACK, D.D.S.
1156 N. 22nd St., Suite A
Laramie, WY 82072

Welcome to our office!! We are committed to providing you the best quality dental care available. This service is based on a friendly, mutual business-like understanding between doctor and patient. Misunderstandings can be minimized if financial policies are presented and discussed at the beginning of treatment. The following is a summary of our financial policy. If you have any questions regarding them, please feel free to ask.

FINANCIAL POLICY

All new patient first visits and emergency visits are to be paid at the time of service.

For subsequent treatment you can:

--Qualify for extended financing with Care Credit healthcare financing.
(You will need to complete a short credit application.)
--**Make payment in full** with cash or check and **receive a 5% discount.**
Senior citizens paying in full receive a 10% discount.
--Provide dental insurance information to pay a portion of your treatment.
--We accept cash, checks, VISA and Mastercard for all treatment.

For procedures that require more than one visit (root canals, crowns, bridges, partial dentures), we ask that **one half of the total charges** be paid at the time of the first visit and the remainder upon completion of the procedures.

DENTAL INSURANCE POLICY

In order for you to utilize your dental insurance for payment on any treatment with us, you must provide an identification card or some other proof of insurance on your first visit**. You will be required to pay your estimated co-insurance portion of the charges for each day of service**. The estimated portion provided by this office is to be considered a guideline until the final insurance payment is received and the patient's account has been reconciled. As a courtesy, this office will fill out and mail dental insurance forms to your insurance company.

If any changes are made to your insurance, it is the responsibility of the patient to inform us of those changes. We are not responsible for any non-payment from the insurance if you have not informed us of any changes to your insurance information. There are several dental insurance companies that we do not accept for payment-- please feel free to inquire about your insurance plan before any treatment is received.

MONTHLY BILLING

Statements of account balances are due in full by the 15th of the month following the billing cycle, unless you have qualified for other arrangements with the office manager.

ANY ACCOUNTS DELINQUENT 90 DAYS WILL BE SENT TO COLLECTIONS.

BROKEN APPOINTMENTS/RETURNED CHECKS

Please call our office if you are unable to keep an appointment. Any appointments canceled or missed with less than 24 hours notice will be subject to a **missed appointment fee of $30.00**. It is our office policy that if you miss more than 3 appointments, we will not schedule any further appointments for you and your immediate family.

Returned checks will be subject to a $25.00 service charge.

Unusual circumstances may require exception to the above policies. If so, please make arrangements with the office manager prior to any treatment.

I have read, understand and received, if requested, a copy of this financial policy.

Patient's signature:_____ **Date:**_____
(Parent or Guardian)

Revised 02/05/07

Albany County Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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 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)

_____

_____

_____

Albany County Family Dentistry

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 INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about 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 04/02/2003, 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 a 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 use 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 Operations: 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 qualification of healthcare professionals, evaluating 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 us written authorization to use your health information or 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 this 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 discuss 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 identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of 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 disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of 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 are 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 also disclose to correctional institution or law enforcement official having lawful custody of protected 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 voicemail 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 we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $7.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these 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 alternative means or to an alternative location. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 writing, and it must explain 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 this Notice in written form.

QUESTIONS AND COMPLAINTS

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

Contact Officer: Byron W. Killpack, D.D.S.
Telephone: (307) 755-0444
Address: P.O. Box 1150 Laramie, WY 82073
Fax: (307) 755-0808