kersey dental
all smiles

INSURANCE AND FINANCIAL POLICY

At our office we believe that you deserve the best care. That is why we always present you with the best dental solution possible. Each year we provide outstanding dental care to hundreds of patients. Some have dental insurance benefits and some do not.

If you have dental insurance, these benefits are based on a contract between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. These are only meant to assist you.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payments by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but this is only an estimate. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket expense. We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. Ultimately, you are responsible for all charges incurred in our office.

We accept MasterCard, Visa, cash and checks. We also offer outside financing through Chase Financial and CareCredit. Please ask our receptionist for more information and an application packet if you are interested.

Broken Appointments: A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we ask that you give us **at least 24 hours notice** to avoid a **$25 cancellation fee** (emergencies are an exception).

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask us.

Payment is expected at the time of service.

I will pay today by _____ Cash _____ Check _____ Visa _____ MasterCard

I have read and understand the payment policy.

Signature: _____ ***Date*** _____

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Thank you for choosing our office. We want your visit to be pleasant and comfortable. Please help us by completing this form. Thank You!

Name _____
Last First MI Preferred Name

DOB_____ SSN_____ Marital Status _____ Sex _____

Address _____
Street City State Zip

Phone _____ _____
Home Work Cell Email Address

Emergency Contact _____
Name Relation Phone Number

Employer _____

Parent/Responsible Party (if under 18) or Spouse Information:

Name _____
Last First MI Relationship

DOB_____ SSN_____ Marital Status _____ Sex _____

Address _____
Street City State Zip

Phone _____ _____
Home Work Cell Email Address

Employer _____

Insurance Information

Primary Dental Carrier

Subscriber Name _____ SSN _____ DOB _____

Employer_____ Insurance Co _____

Insurance Co Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ SSN _____ DOB _____

Employer_____ Insurance Co _____

Insurance Co Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement

I hereby authorize payment directly to the practice of Doug Kersey, Jr., D.M.D. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the practice of Doug Kersey, Jr., D.M.D. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

Medical History and Information

Conditions

- ☐ Abnormal Bleeding
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pace Maker
- ☐ Pregnancy (# mos _____)
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Problems

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics (Novacain, etc.)
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other:

_____

_____

_____

Health / Lifestyle Questions

1. Do you smoke? Yes _____ No _____
2. Do you use tobacco? Yes _____ No _____
3. General Health Good _____ Fair _____ Poor _____
4. Are you currently under a doctor's care? Yes _____ No _____ Doctor's Name _____
5. Have you ever been advised by a physician to premedicate with antibiotics before a dental appointment? Yes _____No _____
6. Have you taken blood thinner in the past 24 months? Yes _____ No _____
7. Have you ever had an emotional condition requiring treatment? Yes _____ No _____

Please list any medications you are currently taking:

_____

_____

_____

Other Information

How did you hear about us? _____

What was the date of your last dental visit? _____

Have you ever had any complications following dental treatment? If so, what? _____

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and parent and guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Signature_____ Date _____

KERSEY DENTAL
DOUG KERSEY, JR., D.M.D.

110 KIA DRIVE
LAGRANGE, GEORGIA 30241

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 receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign.

( ) Communication barriers prohibited obtaining the acknowledgement.

( ) An emergency situation prevented us from obtaining acknowledgement.

( ) Other (please specify):

_____

_____

_____

_____

KERSEY DENTAL
DOUG KERSEY, JR., D.M.D.

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 April 14, 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 health care 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 to include quality assessment and improvement activities, reviewing the competence or qualifications 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 disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment to 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 or 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, xrays, 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 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 disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPPOINTMENT REMINDERS: we may use or disclose your health information to provide you with appointment reminders such as voicemail, messages, postcards, emails 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 can not 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 expenses 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 per page, $ 0 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 a 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 June 1, 2008. 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 bide 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 alternative locations. (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 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 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 our 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 in 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 their address 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:	**Ashley M. Kersey**
TELEPHONE:	**(706) 242-9222**
FAX:	**(706) 242-9220**
ADDRESS:	**110 Kia Drive**
	Lagrange, Georgia 30241
Email:	**ashley@kerseydental.com**