Fox River
Oral and Maxillofacial Surgery, LLC
www.foxriveroralsurgery.com

Patient Name: _____ Date of Birth: _____

Address: _____

Cell #: _____ **Can we text you?** Yes__ No ___ Home #: _____

Work #: _____ SS#: _____

Email Address: _____

Insurance Policy Holder's Name: _____ Date of Birth: _____

Address: _____

Home/Cell #: _____ Work #: _____ SS#: _____

Insurance Company: _____ Employer: _____

Subscriber ID #: _____ Group#: _____

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding about payment policy.

Please initial

_____

We will be happy to process any insurance claims for you. When fee(s) are submitted for insurance pre-determination, the insurance company notifies you, and/or Fox River Oral and Maxillofacial Surgery, LLC in writing. This process can take up to 4-8 weeks. You will be responsible only for the difference between the total surgical fee(s) and the insurance benefits allowed from your plan. However, if the surgery proceeds without receipt of the pre-determination, **you will be responsible to pay a down payment on the date of services rendered. (Example: Standard down payment for extraction of wisdom teeth is $700)** Once payment is received from your insurance company, if your down payment exceeded the amount your insurance company indicated as your portion, we will issue a refund check to you for the difference. An insurance claim will then be filed for the actual date of service. If your deductable has not been met, you will be responsible for the payment of the deductible plus the balance of the total surgical fee.

Please initial

_____

There is a $42.00 fee charged for any non-sufficient funds (i.e. returned checks). Balances that are older than 30 days will be subject to an additional interest charge of 5% monthly. Existing accounts that were delinquent in paying will be required to pay in full for futures charges. A charge or $79.00 may also be applied for broken appointments upon the second time of cancelling. Any balance on the account, regardless of insurance being outstanding, must be paid within 90 days from the date of service. If you do not have insurance, payment in full is due the day services are rendered.

Our office accepts credit cards, including Care Credit. Please let us know if you are interested, we will provide you with Care Credit's information.

The person who signs this financial policy is financially responsible for the account. The social security number of this person is required. If you choose NOT to provide your social security number, you must pay in full with cash, credit, or a cashier's check, for any services rendered.

By signing below, I understand that I am financially responsible for all charges. I also understand that in the event of appointment alterations without adequate (24 hours) notice, additional charges may apply.

_____ _____

SIGNATURE OF PATIENT/PATIENT'S GUARDIAN **DATE**

**** If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Representative Name: _____

Relationship to patient: _____

Home/Cell #: _____

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** PLEASE ANSWER EACH AND EVERY QUESTION **

Patient's Name: _____ Date of Birth: _____

Your current health is: Good ☐ Fair ☐ Poor ☐

Are you currently under a physicians care? Yes ☐ No ☐

If so, please describe reason: _____

Treating physician's name: _____ Phone no. _____

Have you had any serious illness, operations, or hospitalizations? Yes No

If so, please describe and give approximate dates: _____

Have you ever had intravenous sedation, or general anesthesia? Yes No

If so, were there any adverse effects? Yes No

How do you tolerate dental/oral treatment? Good Fair Poor

Do you have, or have you ever had:

(Y) (N) Heart disease detected at birth

(Y) (N) Rheumatic fever or rheumatic heart disease

(Y) (N) Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, or a pacemaker

(Y) (N) Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, or a severe cough)

(Y) (N) Neurologic disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)

(Y) (N) Blood disease (bleeding disorder, anemia, blood transfusion)

(Y) (N) Do you bruise easily

(Y) (N) Kidney disease

(Y) (N) Diabetes

(Y) (N) Thyroid disease (hypothyroidism, tumor)

(Y) (N) Arthritis - if so, which joints: _____

(Y) (N) Stomach ulcers or intestinal problems

(Y) (N) Glaucoma

(Y) (N) Frequent or reoccurring mouth sores

(Y) (N) Implants/artificial joints anywhere in your body (heart valve, knee, hip)

(Y) (N) Noises in jaw joint, pain near ear when chewing, grind or clench teeth

(Y) (N) Sinus or nasal problems

(Y) (N) Any disease, drug or transplant operation, that has depressed your immune system

(Y) (N) Recurring infections of any kind

(Y) (N) Hay fever or frequent skin rashes

(Y) (N) Do you have any other disease, condition or concern that is not listed above that you think the doctor should know about? If so, please describe:

_____

_____

Are you taking or using any of the following:

(Y) (N) Antibiotic
(Y) (N) Anticoagulants (blood thinners)
(Y) (N) Thyroid medications
(Y) (N) Antihistamines, decongestants
(Y) (N) High blood pressure or heart medication
(Y) (N) Steroids
(Y) (N) Tranquilizers, antidepressants
(Y) (N) Stomach medications (antacids, etc.)
(Y) (N) Cholesterol reducing drugs
(Y) (N) Aspirin, ibuprofen, NSAIDS, Anti-inflammatory drugs, narcotics, opioids, or other pain relievers
(Y) (N) Weight reduction pills or diet aids (over the counter or "natural" products.)
(Y) (N) Vitamins, natural remedies (ginkobiloba, ephedra, ginseng, etc.) or other supplements
(Y) (N) Marijuana, cocaine, or other "recreational" drugs
(Y) (N) Any other regular medications, pills, supplements or drugs, if so, please list below:

_____

_____

Are you allergic to or had a bad reaction from:

(Y) (N) Local anesthetic (Novocain – like drugs)
(Y) (N) Penicillin, amoxicillin, cephalosporin
(Y) (N) Other antibiotics
(Y) (N) (Y) (N) Barbiturates, sedatives
(Y) (N) Aspirin, ibuprofen, NSAIDS, or other pain relievers
(Y) (N) Codeine or other narcotics or opioids
(Y) (N) Latex
(Y) (N) Other allergies or reactions: _____

_____

(Y) (N) Do you use alcohol? If so, how much per day/week/month_____
(Y) (N) Do you smoke? If so, what product? _____ For how long? _____
(Y) (N) Do you use chew tobacco? If so, for how long? _____
(Y) (N) Are you in, or have you ever been in a drug or alcohol recovery program?
(Y) (N) Do you wish to speak to the doctor privately about anything?
(Y) (N) Any additional comments or concerns? _____

For Women:

(Y) (N) Are you taking birth control pills?
(Y) (N) Are you pregnant, or trying to become pregnant, or is there <u>any chance</u> that you might be pregnant?
(Y) (N) Are you taking hormonal replacements?

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above it complete and accurate.

_____ _____ Doctor's Initials

Signature of patient/patient's guardian Date

THANK YOU

****

MEDICAL UPDATES

* Please fill out this section **ONLY** if you are a **returning** patient updating your medical history/information*

I have reviewed my health history dated _____ and confirm that it accurately states past and present conditions.

Exceptions:_____

_____ _____

Signature of patient/patient's guardian Date

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CONSENT FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

Patient's Name: _____

Address: _____

Phone- Cell: _____ Home: _____

Work: _____

social Security: _____ Date of Birth: _____

My protected health information is private and confidential. I understand that my doctor and his/her staff work very hard to protect my privacy and preserve the confidentiality of my protected health information.
I understand that my doctor and his/her staff may use and disclose my protected health information to help provide health care to me, to handle billing and payments, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.
I can ask my doctor to limit how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his/her staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that my doctor or his/her staff can give me called "Revocation of Consent for Use and Disclosure of Health Information", or
2. Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my protected health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his/her staff do not have to provide any further health care services to me.
My doctor has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice". If I ask, my doctor or his/her staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices". My signature means that I agree to allow my doctor to use and disclose my protected health information to carry out treatment, payment, and healthcare operations.

_____ _____

Patient (or legally authorized individual) signature Date

_____ _____

Relationship to patient (parent, legal guardian, etc.) Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____, have received a copy of the Fox River Oral Surgery Notice of Privacy Practices.

{Signature}_____ {Date} _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name_____

Relationship to Patient_____

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)

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:

Fox River Oral Surgery and Maxillofacial Surgery, LLC

1500 Carlemont Drive Ste F

Crystal Lake IL 60014

815-356-3977

OUR OBLIGATIONS:

We are required by law to:

Maintain the privacy of protected health information

give you this notice of our legal duties and privacy practices regarding your health information

Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to River Oral Surgery and Maxillofacial Surgery, LLC * Address: 1500 Carlemont Drive Ste F, Crystal Lake IL 60014.

We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format.

If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to River Oral Surgery and Maxillofacial Surgery, LLC
* Address: 1500 Carlemont Drive Ste F, Crystal Lake IL 60014.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to River Oral Surgery and Maxillofacial Surgery, LLC * Address: 1500 Carlemont Drive Ste F, Crystal Lake IL 60014.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Fox River Oral Surgery and Maxillofacial Surgery, LLC * Address: 1500 Carlemont Drive Ste F, Crystal Lake IL 60014We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Fox River Oral Surgery and Maxillofacial Surgery, LLC * Address: 1500 Carlemont Drive Ste F, Crystal Lake IL 60014. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.foxriveroralsurgery.com.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Office Manager at Fox River Oral and Maxillofacial Surgery, LLC Surgery. All complaints must be made in writing.

You will not be penalized for filing a complaint.