HEALTH HISTORY (All responses are kept confidential)

Patient's Name _____ Date _____

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam_____
4. Have you ever had any serious illnesses, Operations or hospitalizations? If so describe Y N

_____

_____

5. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Migraine Headaches? Y N
     If so how often do you have headaches?
     _____
   - B. Do you have Sleep Apnea? Y N
   - C. Rheumatic Fever of Rheumatic Heart Disease? Y N
   - D. Congenital Heart Disease? Y N
   - E. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) Y N
   - F. Lung Disease (Asthma, Emphysema, Chronic Cough, Brochitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain?) Y N
   - G. Seizures, Epilepsy, Fainting, Dizziness Psychiatric Treatment, or other Nervous Disorder? Y N
   - H. Bleeding Disorder, Anemia, Blood Transfusion? Do you bruise easily? Y N
   - I. Liver Disease? (Jaundic, Hepatitis)? Y N
   - J. Kidney Disease? Y N
   - K. Diabetes? Y N
   - L. Thyroid Disease (Goiter?) Y N
   - M. Arthritis? Y N
   - N. Stomach Ulcers or Colitis? Y N
   - O. Glaucoma? Y N
   - P. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee?) Y N
   - Q. Radiation (X-ray) treatment for Cancer? Y N
   - R. Clicking or popping of jaw joint, pain near ear, Difficulty opening mouth, grind or clench teeth? Y N
   - S. Sinus or Nasal problems? Y N
   - W. Any disease, drug or transplant operation that Has depressed your immune system? Y N
   - X. HIV, AIDS Y N

6. Are you taking any:
   - A. Anticoagulants (Blood Thinners?) Y N
   - B. Steroids (Cortisone, etc. Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen Y N
   - D. Osteoporosis medications (fosamax, boniva etc.) Y N
   - E. List all medications you are currently taking:

   _____

   _____

   - F. List any Herbal or Holistic remedies, Vitamins or over-the-

   _____

7. LIST ANY DRUG ALLERGIES:

   _____

   _____

   Are you allergic to latex? Y N
8. Height _____ Weight _____ Age _____

   Date of Birth _____
9. Do you smoke or chew Tobacco? Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N
11. Have you had any serious problems associated with any previous dental treatment? Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? Y N
15. Do you wish to talk to the doctor privately about anything? Y N
16. FEMALES ONLY
    - A. Are you Pregnant, or <u>is there any chance</u> that you might be Pregnant? Y N
    - B. Are you nursing Y N
    - C. Antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the Opportunity to discuss my Health History with my doctor.

_____ _____ _____

Date Signature of Person Completing Health History Doctor's Initials

Vital Signs BP _____ HR _____ RR_____ Temp _____

Glucose Level(s) if applicable _____

Xrays reviewed by Doctor _____ initials. Date _____

Oral-Facial Surgical Arts PA. FINANCIAL POLICY

Ronald M. Achong DMD, MD.

Methods of Payment
(Personal Checks are Not accepted, However, We will accept Certified Bank Checks)
Cash, Debit, Certified Bank checks, Visa, Mastercard, Discover, American Express, Cashiers checks and Money orders are all accepted.

Financial Account Information
Our office will collect full payment from any patients or legal guardians who refuse to provide us with their Social Security number. If requested, a claim may be filed on your behalf for insurance reimbursement.

Third Party Financing
Please ask about our third party financing so that we can offer you the treatment that is recommended.

Collections
In the event that an outstanding bill is unpaid, a letter from the collection agency will be mailed to notify you of the outstanding balance. If this balance is still unpaid, the collections agency will fully intervene. Patients will be responsible for all collection, attorney fees and litigation cost associated with their account.

Missed Appointments
Once an appointment has been made for surgery, you must give us at least 48 (forty eight) hours notice if you need to cancel or reschedule the appointment. If you fail to do so, the full amount of your surgery will be due before scheduling another appointment and a $50 feel will be assessed to you.

Insurance
Your insurance policy is a contract between you and your insurance company. Updated records on most insurance plans are on file however, it is your responsibility to notify us of any changes in your insurance coverage. Payment for all insurance co-pays or non-covered services is due prior to any procedure rendered. It is **not** our policy to bill any secondary insurance companies.

I, the patient, am responsible for all amounts not covered by my insurance carrier. If for some reason, the account should become delinquent, (balance greater than **60 days** from the date of treatment) I agree to pay for all rebilling charges, interest charged, collection cost and attorney fees.

_____ _____

Signature of patient / responsible party Date

Signature on File

Your signature is necessary for us to

1. Process all insurance claims,
2. To ensure payment for services rendered,
3. To release medical information to insurance companies, and
4. To release information to other medical/dental providers, when necessary, for your treatment.

I authorize the release of all medical and dental information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled to Dr. Achong. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____ Date _____
(Parent or guardian, if minor)

Witness _____ Date _____

Authorization for Use and/or Release of Information

Oral Facial Surgical Arts Pa. (352) 243-5599

Patient Name: _____ Date of Birth _____
First Middle Last

Address: _____
Street City State Zip

Social Security #: _____

Name and address of covered entity authorized to use and/or release information:
3180 Citrus Tower Blvd. Clermont, FL 34711
10437 Moss Park Rd. Orlando, FL 32832

The above name entity is authorized to disclose protected health information to the entity or individuals named below:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

It is frequently necessary for personnel at Oral Facial Surgical Arts PA. to communicate lab results, reports, instructions, information about treatment, and other protected health information with our patients. In the event that our personnel are not able to speak with you directly, what other ways can we communicate with you (check all that apply):

___ Leave Voicemail for me at phone number(s): _____

___ Leave message with: _____ at phone number _____

___ email: _____

___ Other _____

This authorization shall be in force and full effect until: Date of expiration _____ (or) the conclusion of my treatment.

Print Name: _____

Signature: _____ Date: _____

Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Elect to opt out of receiving further fundraising communications from the office/hospital
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Maureen at 352-243-5599, in person or in writing, during normal hours. S[he] will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and

- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Maureen at 352-243-5599.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Maureen. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is 3180 Citrus Tower Blvd, Clermont, FL 34711. info@oralsurgicalarts.com

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

Marketing

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

Fund Raising

- We may contact you as part of a fund raising effort.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Funeral Directors/Coroners

- We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Name Date