Piedmont Periodontics, PC
Michael Scott Bartruff, DMD

PATIENT REGISTRATION INFORMATION

Welcome to our practice!
Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help!

Name_____
First *Middle* *Last*
Home Address_____City_____ State_____ Zip_____
Birthdate _____ Age _____ Social Security # _____
Home Phone _____Work Phone _____Cell Phone_____
E-mail Address _____
Referred by _____

Responsible Party

Name of responsible party _____
First *Last* *Relationship*
Address (if different from above) _____ Home Phone _____
City, State, Zip _____ Birth date _____
Driver's License # _____ Social Security #_____
Employer _____ Work Phone _____

Insurance Information

Name of insured _____
First *Last* *Relationship*
Birth date _____ID#_____Social Security # _____
Employer _____ Work Phone _____
Insurance Company _____ Phone # _____
Subscriber ID #_____ Group #_____
Ins. Co Address _____City _____ State _____ Zip _____
If you have dual insurance:
Subscriber Name _____ Social Security # _____
Employer _____Work Phone # _____
Insurance Company _____ Group # _____
Ins. Co Address _____ City _____ State _____ Zip _____

Financial Arrangements

We will gladly bill your insurance for you and estimate your share at the time of treatment. Payment for your portion is due at time of service. For your convenience we offer the following methods of payment (Please circle the option you prefer): Cash Check Amex Visa MasterCard Discover

A billing charge of 1.5% monthly is assessed on balances over 60 days

I acknowledge that I am financially responsible for all charges. If it becomes necessary to commence collections of any amount owed on this and subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that missed or cancelled appointments without proper notification (see "our Policies") will result in a $50 per scheduled hour fee. I authorize Dr Bartruff's office to bill my insurance. I release any information needed and assign benefits to Piedmont Periodontics, PC.

In Case of Emergency

Name:_____Relationship: _____
Phone No: _____Address: _____

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Patient Dental History

What is the primary reason for your visit? (Chief Complaint)

_____

When was your last dental visit? _____ Your last deep cleaning? _____
Have your previous dental experiences been favorable? _____ if not, please explain _____
_____
_____
Name of your dentist and/or periodontist _____
Reason for change _____
When were your last x-rays/radiographs taken? _____FMX _____ Panorex _____
Please indicate with a check if you have had, or have any of the following?

_____ Teeth sensitive to _____ cold _____ heat _____ sweets _____ pressure
_____ Frequent toothache
_____ Habitual grinding or clenching of teeth*
_____ Clicking or popping of jaw joints
_____ Gum boils or abscesses
_____ Bleeding gums
_____ Gum Recession *
_____ Periodontal (gum) treatment*
_____ Frequent filling replacement
_____ Discolored teeth
_____ Orthodontic treatment (braces)
_____ Injury to face or jaw
_____ Wisdom tooth removal

*Type of periodontal treatment completed?
_____

Patient Medical History

This information will help out in preventing serious medical complications or contagious disease. Any information given will be held in strictest confidence and will be released only with your written permission.
Name of Physician _____ Date of last physical _____
What medications have you taken in the last three months? _____
_____
Are you under medical treatment? _____ if yes, describe _____
_____
Do you or did you smoke or use smokeless tobacco? _____ If yes, how much? _____
Have you ever had a reaction to any of the following: **Penicillin Erythromycin Aspirin Codeine**
(Circle One)
Other _____

Is your general health good?	**Yes No**	Bleeding Problems	**Yes No**	Seizures	**Yes No**
Has there been a change in		TB Tuberculosis	**Yes No**	Herpes	**Yes No**
your health within the last year?	**Yes No**	Artificial Joint *	**Yes No**	Asthma	**Yes No**
Have you been hospitalized or had a		Sleep Apnea	**Yes No**	Hepatitis	**Yes No**
serious illness in the last 3 years?	**Yes No**	Do you have or have you had:		Anemia	**Yes No**
Have you had or been treated for:		Diabetes	**Yes No**	Stroke	**Yes No**
Heart attack	**Yes No**	Psychiatric care	**Yes No**	Allergies	**Yes No**
Heart murmur*	**Yes No**	Radiation treatments	**Yes No**	Cancer	**Yes No**
High blood pressure	**Yes No**	Chemotherapy	**Yes No**	(Women)	
Rheumatic fever*	**Yes No**	Prosthetic heart valve*	**Yes No**	Are you pregnant?	
HIV Positive / AIDS*	**Yes No**	Pacemaker	**Yes No**		**Yes No**
Are you taking Blood Thinners	**Yes No**	Are you taking medication for Osteoporosis			**Yes No**

Has your medical doctor advised you to pre-medicate before dental procedure? **Yes No**

Signature _____ **Date** _____
(To be completed by doctor) Medical record reviewed by:
Initials_____ Date_____ Initials _____ Date _____

Initials_____ Date_____ Initials _____ Date _____

Piedmont Periodontics, PC
Michael Scott Bartruff, DMD

PIEDMONT PERIODONTICS-OUR POLICIES

WELCOME to Piedmont Periodontics. It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations.

-- If you have dental insurance, we will be glad to help you to receive your maximum allowable benefits.

The following is our policies and are established to serve your and our best interest. Please initial each policy.

- Payment is due at the time services are rendered. We accept Cash, Checks, MasterCard, Visa, American Express, and Discover. _____
- **If you are a patient with insurance, it is important to remember that your insurance plan is a contract between you, your employer, and the insurance company. The contract is in no way a binding obligation between the Dental Insurance Company and Piedmont Periodontics, PC**. _____
- Our fees generally fall within the acceptable range of the maximum allowance determined by each insurance carrier. This applies only to companies, which pay a percentage of "Usual, Customary, and Reasonable (UCR)," rates. This does not apply to companies, which reimburse based on an arbitrary "schedule" of fees. _____
- After your initial exam you will receive a treatment plan which estimates your portion of payment. **If we estimate and collect your co-payment and the insurance underpays or denies a benefit, you are responsible for the remaining balance.** _____
- We encourage a submitted insurance pre-determination be sent to your insurance company, this will determine which procedures might be covered and calculate your co-payment. A pre-determination does not guarantee payment from your insurance company. _____
- Not all services are covered in all insurance contracts. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium/contract arranged by your employer. Our office will comply with ADA standards in filing codes to your insurance company and will not allow insurance companies to dictate treatment. _____
- In order for us to help you process your insurance claim for your reimbursement, please bring all insurance information with you. Also, please call your dental insurance carrier to expedite claims if a claim is not paid within 30 days, as the law requires. _____
- Returned checks and outstanding balances over 60 days are subject to any collection fees and an interest rate of 1.5% will be assessed to your account monthly until balance is paid in full. _____
- **Cancellation Policy** – in order to cancel or re-schedule an appointment, please adhere to the following formula to determine the acceptable amount of time needed to cancel or change an appointment: 1 business day per hour of scheduled time plus 2 business days, i.e. a 3 hour appointment would require 5 business days to cancel or change the appointment. Any appointment where this policy is not honored, a $50 charge per hour of appointment will be assessed to your account. If you neglect to contact us to cancel or change an appointment or are a no-show but wish to re-schedule the treatment that was missed, you will be required to pay 50% (non-refundable) of the fees for treatment in order to re-schedule. If you miss two scheduled appointments without notifying our office, you will be dismissed. Please remember that the staff sets aside a designated amount of time for your particular type of treatment. We appreciate your understanding of how important keeping your appointment is to the doctor and our other patients. _____
- **Deposits** – after initial consultation, any treatment scheduled WILL require a deposit or your estimated patient portion to be paid prior to scheduling the appointment. _____

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information or insurance coverage, please do not hesitate to ask …we are here to help!

Our financial policy is designed to keep our fees as low as possible. Our goal is to stay competitive and offer the best quality dental care to everyone. Please help us achieve our goal by a mutual respectful relationship. We look forward to a long happy relationship with you. Please do not hesitate to ask our staff for anything that might make your visit more enjoyable. We are all here for you, and welcome any constructive comments.

Sincerely,

Michael Scott Bartruff, D.M.D. and staff

I have read and understand the above office financial policy.

Patient or responsible party signature Date

Piedmont Periodontics, PC
Michael S. Bartruff, DMD

ASSIGNMENT OF BENEFITS AGREEMENT

Piedmont Periodontics PC is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. It must be clearly understood that the "contract" is between the patient and the insurance company, the account thereby being the responsibility of the patient for any amount not paid by the insurance company. Following is a statement of our policies governing insurance claims.

-- Although we are willing to complete insurance information forms and submit a claim on behalf of the patient, we do not accept responsibility—under any circumstance—for the outcome of the transaction. Completing insurance forms is a courtesy we extend to our patients in an effort to maximize their likelihood of obtaining insurance reimbursement. By having our office process insurance forms, the patient agrees to accept liability for those forms. Alternatively, a patient may fill out his/her own insurance forms and bill the insurance directly.

-- We require our patients to sign an "authorization to Pay the Doctor" form (or any other necessary assignment documents required by your insurance company). By doing so, the insurance company will make payments directly to our office.

-- The patient will pay the co-payment (the amount not covered by the insurance company) at the time services are rendered.

-- Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patient's insurance company has not made payment to our office within 60 days, we may request the patient to pay the balance due and then seek reimbursement from the insurance company when and if they pay.

-- Our office does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason the patient's claim is denied, the patient is then considered to be responsible for the full amount of the bill.

-- Our office will not enter into a "dispute" with an insurance company over any claim, although we will work with the insurance company to sort out any confusions or questions which might arise. We will cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.

If you understand and agree to all of the above office policies, please sign your name below and we will accept your insurance assignment.

_____ _____
Signature of Patient/Legal Guardian Date

_____
Print name

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on **May 8th, 2013** and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Regan Retzloff. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your protected health information (PHI) including electronic protected health information (ePHI) to provide you with our professional services which may include electronic disclosure. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

(a) Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your health information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $**0.00** for each page and the staff time charged will be $**0.00** per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

(b) Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

Payment: We may use and disclose your PHI and ePHI to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get electronic copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $**0.00** for each page and the staff time charged will be $**0.00** per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to request and receive an accounting of certain non-routine disclosures of your identifiable health information. We are required to maintain a log of these non-routine disclosures for a period of no less than six years beginning April 14, 2003. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is 'breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Practice Name: **PIEDMONT PERIODONTICS** Privacy Officer: REGAN RETZLOFF

Telephone: **404-815-4800** Fax: **404-815-0002**

Address: **222 12TH STREET, STE 1B, ATLANTA, GA 30309**

Email: **regan@piedmontperiodontics.com**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:	
Patient's Date of Birth:	Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____
Patient's Signature or Signature of Patient's Representative Date

_____
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: **Regan Retzloff**		
Practice Address: **222 12th Street Ste 1B, Atlanta, GA 30309**		
Phone: **404-815-4800**	Fax: **404-815-0002**	E-Mail: **regan@piedmontperiodontics.com**

Piedmont Periodontics