endodontic
wellness center

Patient Forms:

Print our and complete the forms
and bring with you at your appointment.

4830 Knightsbridge Blvd.
Suite L.,
Columbus, OH 43214

endodonticwellness.com

ENDODONTIC WELLNESS CENTER
Acknowledgement of Receipt of Notice of Privacy Practices

This sample form illustrates how a dental practice could obtain acknowledgement of receipt of its Notice of Privacy Practices or document its good faith effort to obtain that acknowledgement.

Endodontic Wellness Center

* You May Refuse to Sign This Acknowledgment*

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

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____

HAASE D.D.S. INC.

AUTHORIZATION AND CONSENT TO SEND UNENCRYPTED PATIENT INFORMATION BY EMAIL AND OTHER ELECTRONIC MEANS

Until I tell you in writing to stop, I authorize Haase D.D.S. Inc to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and other involved in my treatment, payment for my treatment, or Haase D.D.S. Inc's health care operations.
The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

*I do not have to sign this form.

*My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.

*If I don't sign this form, Haase D.D.S. Inc. may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself

*There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.

*Haase D.D.S. Inc. does not email such sensitive personal information as Social Security numbers, credit card numbers, mental health diagnoses, genetic information, alcohol/substance abuse information, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Haase D.D.S. Inc. already sent before receiving my written instructions to stop.

Patient name: _____

Signature: _____ Date: _____

MUTUAL UNDERSTANDING / CONSENT FOR TREATMENT

I, the undersigned, after consulting with the doctor, consent to the performing of whatever procedure may be decided upon to be necessary or advisable in the opinion of the doctor.

I understand that root canal treatment is an attempt to save a tooth which otherwise requires extraction. Elective root canal therapy may be performed to provide space to anchor a final restoration and/or crown when insufficient tooth structure remains or to relieve excessive sensitivity to temperatures or as an adjunct to other specialty treatment. Although root canal therapy has a high degree of success, it is still a biological procedure, so success cannot be guaranteed or warranted. Occasionally, a tooth that has had a root canal may require retreatment, surgery or even extraction.

It will be explained to me that there are certain inherent and potential risks in any treatment or procedure, including extraction and/or dental implant placement which may be alternative treatments instead of root canal therapy. I understand that the following may be potential risks of root canal treatment: numbness and/or a tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasion may be permanent; treatment failure; complications resulting from the risks of dental instruments (broken instruments, perforation of the tooth, root or sinus); and antibiotics may inhibit the effectiveness of birth control pills.

Swelling or discomfort may be experienced after treatment by some patients. There is no way to predict this. Prescriptions for pain killers and/or antibiotics will be provided if needed.

I will have an opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment and the alternatives to this treatment.

I also understand that only the root canal will be done in this office. The permanent (outside) restoration (filling and/or crown) needs to be done by my regular dentist within a maximum of an 8-week period.

I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at or before the completion of treatment, unless other specific arrangements are made with this office.

Signed _____ Date _____

Parental Permission _____

Endodontic Wellness
Haase D.D.S. Inc.
Andrew J Haase DDS MS
Mark L Oleson DDS MS
Practice Limited to Endodontics
4830 Knightsbridge Blvd Suite L
Columbus OH 43214-2300
(614) 459-2234

FINANCIAL POLICY

Thank you for choosing Midwest Endodontics for your endodontics needs. Our practice is dedicated to providing the best professional advice, care and endodontic treatment for our patients. Please understand that payment of your bill is part of your treatment. The following is an explanation of our Financial Policy for you to read and sign before seeing the doctor.

SELF-PAY PATIENTS:

Payment in Full is due at the time services are rendered. We accept cash, check and most credit cards.
We also offer financing options available through an **ACH Payment Plan** or **CareCredit.**
Please discuss this option with the receptionist if you are interested.

INFORMATION FOR PATIENTS WITH DENTAL BENEFIT INSURANCE:

Your insurance policy is a contract between you and your insurance carrier. It is a contract your employer negotiated with the insurance carrier. There will be a maximum dollar amount of coverage per year.
It is vitally important that you understand your coverage including any waiting periods or non-covered services.

No dental insurance is designed to pay 100% of treatment costs.
Therefore, at the time of treatment we will ask for a percentage payment based on what your insurance carrier will pay for endodontics services.
We offer an **ACH Payment Plan** or **CareCredit** as our financing options for patients who need it.

Our office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance carrier's arbitrary determination of usual and customary rates (UCR).

_____

I have read and understand this Financial Policy Date
Signature of Patient or Responsible Party

ENDODONTIC WELLNESS CENTER
4830 Knightsbridge Blvd. Suite L
Columbus, OH 43214-2300

PATIENT INFORMATION FORM

Patient:

Name_____

Address_____

City_____ State_____ Zip_____

SS#_____ DOB_____

Home phone_____ Cell phone_____ Work Phone_____

Email address_____

Person Financially Responsible for this Account:

Name_____

Address_____

City_____ State_____ Zip_____

SS#_____ DOB_____

Home phone_____ Cell phone_____ Work Phone_____

Email address_____

Primary Dental Insurance_____ Group #_____

Employer_____

Subscriber_____ SS#_____ DOB_____

Secondary Dental Insurance_____ Group #_____

Employer_____

Subscriber_____ SS#_____ DOB_____

HEALTH HISTORY FORM

Referring Dentist_____

General Dentist_____

Are you currently in treatment with an additional specialty dentist? ☐ yes ☐ no
If yes, name? _____

Are you pregnant? ☐ yes ☐ no

List all the medications you are taking:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Have you ever had an allergic reaction to the following:

☐ Penicillin/Amoxicillin
☐ Aspirin/NSAIDS
☐ Latex products
☐ Codeine/Narcotics
☐ Local anesthetic

Any other medications or foods_____

Check any of the following conditions that apply:

☐ Heart surgery
☐ High blood pressure
☐ Pacemaker
☐ Artificial heart valve
☐ Congenital heart conditions
☐ History of infective endocarditis
☐ History of stroke
☐ Diabetes
☐ Joint replacements
☐ Ulcers
☐ Recent surgery
☐ Seizure disorder
☐ Bleeding disorder
☐ Cancer
☐ HIV/AIDS
☐ Hepatitis B or C
☐ Cognitive or memory problems
☐ Asthma
☐ Chronic sinus problems
☐ Kidney problems
☐ Recovering substance abuser
☐ Tuberculosis
☐ Long term oral or IV bisphosphonate therapy for osteoporosis

Name and phone of your doctor_____

Any other information about your health_____

_____

HAASE D.D.S. INC.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect SEPTEMBER 13, 2013 and will remain in effect until we replace it. The current Notice has been updated in compliance with applicable law effective MARCH 13, 2015 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY SEND HEALTH INFORMATION ABOUT YOU

Your protected health information (PHI) includes information relating to your mental or physical health and to the health care provided to you, including materials like your dental records, dental x-rays, and payment records. Some documents containing PHI may include such sensitive personal information as a Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse records, positive HIV status, and other kinds of sensitive information.

Sometimes our dental practice needs to send PHI to the patient or to someone else such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice does not encrypt email or other electronic forms of communication.

There is a risk that unencrypted information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information for you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for your, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

>Prevent or control disease, injury or disability
>Report child abuse or neglect
>Report reactions to medication or problems with products or devices
>Notify a person of a recall, repair, or replacement of products or devices
>Notify a person who may have been exposed to a disease or condition
>Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Workers' Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil right laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format your request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a twelve month period, we may charge youa reasonable, cost based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured PHI as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Website or by electronic mail (email).

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 if 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 the U.S. Department of Health and Human Services.

Our Privacy Official: Dr Andrew Haase

Telephone: 614.459.2234 Fax: 614.451.4388

Address: 4830 Knightsbridge Boulevard Suite L
Columbus OH 43214

Email: patient.support@endodonticwellness.com