DR. JOSEPH E. RUSSELL, D.D.S.

PATIENT INFORMATION

ABOUT THE PATIENT:

NAME:_____SEX_____M_____F

HOME ADDRESS:_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE:(___)_____CELL:(___)_____WORK PHONE:(__)_____

EMAIL ADDRESS:_____

DRIVERS LICENSE NUMBER_____STATE_____EXP DATE_____

(A COPY OF A PHOTO IDENTIFICATION IS REQUIRED FOR INSURANCE PURPOSES)

SOCIAL SECURITY #:_____DATE OF BIRTH_____

PHYSICIAN'S NAME:_____PHONE_____

EMERGENCY CONTACT:_____PHONE_____RELATIONSHIP:_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

WHO IS RESPONSIBLE FOR THIS BILL?_____

_____	_____	___/___	_____	_____
CREDIT CARD TYPE	CARD #	EXP. DATE	3-DIGIT CODE	AUTH. INITIALS

DENTAL INSURANCE INFORMATION

ABOUT THE INSURED PERSON

NAME OF INSURED:_____RELATIONSHIP TO PATIENT_____

INSURED BIRTHDATE:_____ SOCIAL SECURITY NUMBER:_____

NAME OF EMPLOYER:_____OFFICE PHONE NUMBER_____

INSURANCE COMPANY NAME:_____

ADDRESS_____CITY/STATE_____ZIP:_____

GROUP #_____EMPLOYEE ID #_____

DO YOU HAVE **SECONDARY DENTAL INSURANCE**? _____YES_____NO

NAME OF INSURED:_____RELATIONSHIP TO PATIENT_____

INSURED BIRTHDATE:_____ SOCIAL SECURITY NUMBER:_____

NAME OF EMPLOYER:_____OFFICE PHONE NUMBER_____

INSURANCE COMPANY NAME:_____

ADDRESS_____CITY/STATE_____ZIP:_____

GROUP #_____EMPLOYEE ID #_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU.

MEDICAL INSURANCE INFORMATION - SOME DENTAL PROCEDURES MAY BE COVERED BY SOME MEDICAL PLANS.
(PLEASE COMPLETE THE FOLLOWING OR WE CAN MAKE A COPY OF YOUR MEDICAL INSURANCE CARD FOR OUR FILES.)

NAME OF INSURED:_____RELATIONSHIP TO PATIENT_____

INSURED BIRTHDATE:_____SOCIAL SECURITY NUMBER:_____

INSURANCE COMPANY NAME:_____

ADDRESS_____CITY/STATE_____ZIP:_____

GROUP #_____EMPLOYEE ID #_____

MEDICAL HISTORY: Do you have or had any of the following? Please circle those that apply.

AIDS	Diabetes	Pacemaker
Anemia	Epilepsy	Psychiatric Care/Problem
Arthritis/Rheumatism	Fainting	Radiation Treatment
Artificial Heart Valves	Glaucoma	Respiratory Disease
Asthma	Heart Murmur	Shortness of Breath
Back Problems	Heart Attack	Skin Rash
Bleeding Abnormalities	Heart Problems	Sinus Problems
Blood Disease	Hemophilia	Stroke
Cancer	Hepatitis	Thyroid Problems
Chemical Dependency	High Blood Pressure	Tobacco Habit
Chemotherapy	HIV	Positive Tuberculosis
Circulatory problems	Kidney Disease	Liver Disease
Congenital Heart Issues	Cortisone Treatments	Mitral Valve Prolaspe

Please explain any other health conditions not listed above? _____

_____

Please list all **Allergies**:_____

Please list all **Medications** you are taking (if you have a list we can make a copy to attach):_____

_____

WOMEN ONLY:

Are you pregnant?____yes_____no Nursing?___yes____ Had an exposure to HPV?_____yes____no

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professioanl services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept **confidential.**

_____ _____

SIGNATURE **DATE**

JOSEPH E. RUSSELL, D.D.S.
NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make

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reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, emails, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $35 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before January 1, 2011. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost- based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to 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 with the U.S. Department of Health and Human Services.

Contact Officer: Wendy Krenn, Office Manager
Telephone: (440)248-9005
infor@joerusselldds.com
Address: 6200 SOM Center Road
Suite B-14
Solon, Ohio 44139

I have read and understand the privacy practices of Joseph E. Russell, DDS

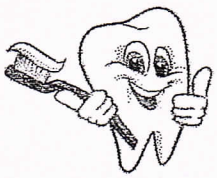
_____ _____

Signature (Guardian if under 18) Date

_____

Name (printed)

PLEASE SIGN AND RETURN THIS PAGE



DR. JOSEPH E. RUSSELL, D.D.S
FINANCIAL AGREEMENT

We, the staff of Dr. Joseph E. Russell, thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact Wendy Krenn, Office Manager, at 440-248-9005.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship.

In order to keep our costs reasonable we require payment at the time of service unless our staff has approved payment arrangements in advance. We make payment as convenient as possible by accepting Cash, Money Order, Credit Cards and in-state checks. A $35.00 service fee will be charged for all returned checks. You may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Credit Card # _____ Exp. Date___/___3 digit code_____initials_____

Interest

Please consult with our office staff regarding payment arrangements **prior** having a procedure done. We will customize a payment schedule based on the treatment plan. **Interest will incur if a balance remains unpaid after 60 days for balances that result from services that were received and no payment plan was established prior to procedure(s).**

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you recieve the maximun allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. W e do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. **When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.**

Missed Appointments

We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us 48 hours in advance, a missed appointment fee will apply. These fees are typically $35.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files and or summaries.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.
We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

_____ _____

Signature of Insured or Authorized Representative Date

_____

Print Name

_____ _____

Office Representive Date

PLEASE SIGN ONE COPY AND RETURN FOR OUR RECORDS
PLEASE KEEP ONE COPY FOR YOUR RECORDS