Care Most Dental

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 or 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 effect. This Notice takes effect April 14, 2003, 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 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 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 health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare 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 healthcare operations. Health 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 anytime. 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 you health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment or 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 disclosures 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 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 official's 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, 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 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 $ 0.50 for each page, $ 15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 purpose, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-months 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.

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 your complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **JANET D. TRAN, DDS, PA**
Telephone: **214-856-3258** Fax: **214-856-3281**
E-mail: **caremostdental@gmail.com**
Address: **3725 S Lake Forest Dr. #108, McKinney, TX 75070**

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

ASSIGNMENT OF BENEFITS AND PAYMENT AGREEMENT

I hereby authorize and notify by this written agreement, signed and dated below, that my insurance carrier assign all proceeds and benefits to which I may be entitled to under their policy issued to me or that I hold certificate to said policy, be assigned to **JANET D. TRAN, DDS, PA, /CARE MOST DENTAL**, for any dental treatment rendered to me, subject only to the exclusions and deductibles of the insurance policy. **SHOULD A BALANCE EXIST IN THE TOTAL BILL AFTER THE INSURANCE CARRIER HAS FUFILLED ITS OBLIGATION UNDER THE POLICY, I REALIZE THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF THE REMAINING BALANCES**. If the insurance carrier of patient fails to make payments for care and services rendered, it is understood that such steps as are authorized by law will be taken for the enforcement of the rights under the Assignment and Agreement.

Note: Our office will reach you directly or by message prior to your appointment to remind and confirm your appointment time. **There will be a $25.00 CHARGE for a broken appointment.**

I have read, understand, and agreed to the above terms and conditions.

Signature (If minor then parent signature) Date

Care Most Dental

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________________ Email: ______________________________

Patient #: ______________________ Social Security #: ______________________________

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Janet D. Tran, DDS, PA

Telephone: (214) 856 - 3258 Fax: (214) 856 - 3281

E-mail: caremostdental@gmail.com

Address: 3725 S. Lake Forest Dr. #108, McKinney, Texas 7507

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ______________________________ Date: ______________________

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

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Care Most Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

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

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This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

DENTAL TREATMENT CONSENT FORM

1. TREATMENT TO BE PROVIDED

I understand that I am to have treatment provided as detailed in the attached treatment plan.

Initials________

2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics, and other medications can cause allergic reaction such as redness and swelling of tissues, pain itching, and vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist of any known allergies to medication.

Initials________

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedure because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additional as necessary.

Initials________

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.), and I authorize the Dentist to remove the following teeth ________ and any others, necessary for reasons outlined in paragraph #3. I understand removing teeth does not always remove the infection, if present and it may be necessary to have further treatment. While complications can be rare, I understand the risks involved in having teeth removed: some of which may be pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parasthesia) that can last for an indefinite period of time or even rarely, a fractured jaw. I understand I may need further treatment by a specialist if complications arise, the cost of which is my responsibility.

Initials________

5. CROWNS AND VENEERS

a) Treatment involves covering the tooth above the gum line with a cap (crown) or covering the front surface or the tooth with a tooth colored bonded porcelain laminate called a veneer. I understand that sometimes it is not possible to match the color, of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive days may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation. Dr. Tran does not endorse the use of base metal in crowns and is not responsible for any untoward or allergic reactions to the metal, nor cost incurred for additional treatment needed to correct the problem associated with base metal crowns.

Initials________

b) I am electing to follow Dr. Tran's recommendation of using high noble metal in my crown and bridge restorations.

Initials________

c) I am electing to do a fixed bridge replacement of missing teeth instead f a removable appliance. I understand that this fixed bridge work may not be a covered benefit under my insurance policy.

Initials________

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment and that occasionally the canal filling material may extend through the tooth root tip, which does not necessarily affect the success of the treatment. Hard to detect root fractures are one of the main reasons why root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. It also prevents a root canal from being re-infected. I understand that endodontic files and reamers are very fine instruments and stresses in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal therapy (apicoectomy). I understand I may need further treatment by a specialist if complications arise, the cost of which is my responsibility. I understand that the tooth may be lost in spite of all efforts to save it.

Initials________

7. PERIODONTAL LOSS (TISSUE AND BONE)
I understand that I have a serious condition, causing gum and bone inflammation and that it can lead to the loss of my teeth and/or supporting bone. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that periodontal disease may have future adverse affect on the long-term success of dent restorative work.

Initials________

8.FILLINGS
I understand that a more extensive restoration than originally diagnosed may be required due to additional decay found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown or both. I understand that sensitivity is a common after effect of a newly placed filing. A certain amount of time (months) may be needed to allow a tooth to be normal. Brief & intermittent sensitivity after a restoration is placed is deemed normal. I understand that posterior composites are considered an upgrade.

Initials________

9. DENTURES – COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. Immediately dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days =, there will be additional charges.

Initials________

10. BLEACHING
Bleaching is a procedure done either in office (1 hour) or with take home trays (2 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change(1-3 shades on a dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand that I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The doctor may prescribe fluoride treatments for rare cases of persistent sensitivity. Carbamide peroxide, and other peroxide solutions used in teeth bleaching are approved by the PDA as mouth antiseptics. Their use as bleaching agents has unknown risk. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

Initials________

11. NITROUS OXIDE
I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand possible side effects that may occur. These include, but are not limited to nausea, vomiting, dizziness, and headache. I also understand that nitrous oxide use is not indicated if I am pregnant.

Initials________

11. DENTAL BENEFITS
I understand that the standard of care at CARE MOST DENTAL is optimal dental treatment and that my insurance may not cover all aspects of this enhanced dental treatment.

Initials________

I understand that dentistry is not an exact science and that, reputable practitioners cannot properly guarantee results. I acknowledge no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to proposed treatment.

Signature of Patient/Parent/Guardian: ____ Date: ___________________