

OUR FINANCIAL POLICY

Dr. Maria Manzor and her professional staff are committed to providing you and your family quality dental care for years to come. Our goal is to educate all of our patients to the best of our abilities about their dental needs. In order to accomplish this task, it is necessary that we also have the utmost cooperation of our patients to ensure their dental health does not become compromised.

Your understanding of our financial policy is important to our professional relationship. Please ask us if you have any questions about our fees or your financial responsibility. Dr. Manzor, DDS, PC is committed to complying with all federal, state and local laws, regulating rules and professional regulatory body guidelines that involve delivery and payment of dental services.

INSURANCE AND PAYMENT FOR SERVICES: We are a “fee for service” dental practice. We accept patients who participate in a variety of dental insurance plans as well as patients who have no insurance at all. In order to provide the best possible dental care at the lowest cost, it is requested that payment be made for all services as they are performed, unless payment arrangements are made prior to treatment. Regardless of a patient’s insurance status, the fees associated with any treatment will be due and expected at the time of service. The estimated amount not covered by insurance (i.e. the “co-pay”) will be expected to be paid by the insured at the time the service is rendered. The patient/insured will be responsible for the outstanding balance not covered by insurance, for whatever reason. Reasonable efforts to obtain insurance benefits for the insurer will be made. The responsibility falls upon the patient/insured to resolve disputes with their insurance company (ies). This is a contractual relationship between the patient and the insurance company, **NOT THE INSURANCE COMPANY AND THE DENTAL OFFICE.**

PAYMENT: We accept cash, money orders, personal checks (no third-party checks), cashier’s checks, Visa, MasterCard, and Discover. Certain patients may qualify for a time-payment contract or a line of credit through Care Credit, an independent finance company extending credit 90 days interest free.

MINORS ACCOMPANIED BY AN ADULT: The parent/guardian accompanying a minor patient will be responsible for signing the minor’s consent and agreement form. The parent or guardian, by signing, assumes the financial responsibility for treatment rendered to the minor until he or she is emancipated or has reached the age of eighteen. Once the minor is emancipated or has turned eighteen, he or she is financially responsible for any treatment received.

SCHEDULED APPOINTMENTS: Patient’s scheduled appointments are just that-scheduled appointments! We make every effort to arrange a convenient time for our patients to attend to their dental needs. Preferably, our office would like 48 hours notice if you are unable to make the scheduled appointment time. At a minimum, we require 24 hour notice of cancellation or rescheduling of appointments. In the event our patients are unable to give a sufficient notice (at least 24 hours) of their inability to make their scheduled appointment, a \$35.00 charge per 1 hour of appointment time will be assessed against their account.

RETURNED CHECKS: Returned checks due to non-sufficient funds will be assessed a \$25.00 service fee.

As a patient you have the responsibility to attend to your dental needs both at our office and at home. Our office will advise our patients of the recommended course of treatment. It is the patient’s ultimate decision, whether or not he/she wishes to participate in the recommended course of treatment.

I ACKNOWLEDGE I HAVE READ AND REVIEWED DR. MANZOR’S FINANCIAL OFFICE POLICY. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS REGARDING THESE MATTERS AND FULLY UNDERSTAND THE ABOVE PARAGRAPHS.

Signature

Date

Medical History

Patient
Name _____ Nickname _____ Age _____

Name of Physician/and their
specialty _____

Most recent physical
examination _____ Purpose _____

What is your estimate of your general health? Excellent / Good / Fair / Poor

HAVE YOU EVER HAD THE FOLLOWING:

| | Yes | No | | Yes | No |
|--|-----|----|--|-----|----|
| 1. hospitalization for illness or injury | | | 27. glaucoma | | |
| 2. allergic reaction to: | | | 28. contact lenses | | |
| Aspirin, ibuprofen, acetaminophen | | | 29. head or neck injuries | | |
| Penicillin | | | 30. epilepsy, convulsions (seizures) | | |
| Erythromycin | | | 31. viral infections and cold sores | | |
| Tetracycline | | | 32. any lumps or swelling in the mouth | | |
| Codeine | | | 33. hives, skin rash, hay fever | | |
| Local anesthetic | | | 34. venereal disease | | |
| Fluoride | | | 35. hepatitis (type _____) | | |
| Metals (gold, stainless steel) | | | 36. HIV/AIDS | | |
| Latex | | | 37. tumor, abnormal growth | | |
| Any other medications | | | 38. radiation therapy | | |
| 3. heart problems | | | 39. chemotherapy | | |
| 4. heart murmur | | | 40. emotional problems | | |
| 5. rheumatic fever | | | 41. psychiatric treatment | | |
| 6. scarlet fever | | | 42. antidepressant medication | | |
| 7. high blood pressure | | | 43. alcohol/drug dependency | | |
| 8. low blood pressure | | | ARE YOU: | | |
| 9. a stroke | | | 44. presently being treated for any illness | | |
| 10. artificial prosthesis (i.e. heart valve or joints) | | | 45. aware of a change in your general health | | |
| 11. anemia or other blood disorders | | | 46. taking meds for osteoporosis/osteopenia | | |
| 12. prolonged bleeding due to a slight cut | | | 47. often exhausted or fatigued | | |
| 13. emphysema | | | 48. subject to frequent headaches | | |
| 14. tuberculosis | | | 49. a heavy smoker (1 pack or more per day) | | |
| 15. asthma | | | 50. considered a touchy person | | |
| 16. sinus problems | | | 51. often unhappy or depressed | | |
| 17. kidney disease | | | 52. easily upset or irritated | | |
| 18. liver disease | | | 53. FEMALE- taking birth control pills | | |
| 19. jaundice | | | 54. FEMALE- pregnant | | |
| 20. thyroid or parathyroid disease | | | 55. MALE- Prostate disorders | | |
| 21. hormone deficiency | | | | | |
| 22. high cholesterol | | | | | |
| 23. diabetes | | | | | |
| 24. stomach or duodenal ulcer | | | | | |

Describe any current medical treatment, impending Surgery, or other treatment that may possibly affect your dental treatment:

List any medications, supplements, and/or vitamins taken within the last two years
Drug Purpose

PLEASE ADVISE IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____

Date _____

Doctor's Signature _____

Date _____

Dental History

Referred by _____ How would you rate the condition of your mouth? Excellent /Good /Fair /Poor

Previous Dentist _____

How long were you a patient? _____ Months/Years

Date of most recent dental exam _____/_____/_____

Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____

I routinely see my dentist every: 3 months 4 months 6 months 12 months Not routinely

What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO **Personal History**

| | Yes | No |
|---|-----|----|
| 1. Are you fearful of dental treatment? Scale of 1-10 (10=very) | | |
| 2. Have you ever had an unfavorable dental experience? | | |
| 3. Have you ever had complications from past dental treatment? | | |
| 4. Have you ever had trouble getting numb or reactions to local anesthetic? | | |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? | | |
| 6. Have you ever had any teeth removed? | | |
| Smile Characteristics | | |
| 7. Is there anything about the appearance of your teeth that you would like to change? | | |
| 8. Have you ever whitened (bleached) your teeth? | | |
| 9. Are you self conscious about your teeth? | | |
| 10. Have you been disappointed with the appearance of previous dental work? | | |
| Bite and Jaw Joint | | |
| 11. Do you/ would you have any problems chewing gum? | | |
| 12. Do you/ would you have any problems chewing bagels or any other hard foods? | | |
| 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? | | |
| 14. Are your teeth crowding or developing spaces? | | |
| 15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? | | |
| 16. Do you have any problems with sleep or wake up with an awareness of your teeth? | | |
| 17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) | | |
| 18. Do you have tension headaches or sore teeth? | | |
| 19. Do you wear or have you ever worn a bite appliance? | | |
| Tooth Structure | | |
| 20. Have you had any cavities within the past 3 years? | | |
| 21. Do you have a dry mouth? | | |
| 22. Are any teeth sensitive to hot, cold, biting or sweets? | | |
| 23. Have you ever had a toothache, cracked filling, broken, chipped, or cracked tooth? | | |
| 24. Do you avoid brushing any part of your mouth? | | |
| Gum and Bone | | |
| 25. Have you ever been diagnosed or treated for periodontal (gum) disease? | | |
| 26. Have you ever experienced gum recession? | | |
| 27. Is there anyone with a history of periodontal disease in your family? | | |
| 28. Do your gums bleed when brushing, flossing, or eating? | | |
| 29. Are your teeth becoming loose? | | |
| 30. Have you ever noticed an unpleasant taste or odor in your mouth? | | |
| 31. Have you experienced a burning sensation in your mouth? | | |

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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Maria Elena Manzor, D.D.S., P.C.
**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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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Maria Elena Manzor, D.D.S., P.C.

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 04/14/2003, 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 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 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, 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 \$5.00 for each page, or \$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 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 April 14, 2003. 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.

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 may also 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: Kim Novacek, Office Manager
Telephone: 1(586) 751-3950
Fax: 1(586) 751-3992
Address: 28633 Hoover Road, Warren, Michigan 48093

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Consent for Use and Disclosure of Health Information

Purpose: In cases where Maria Manzor, D.D.S., P.C. has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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: Maria Manzor

Telephone: 1-586-751-3950

Fax: 1-586-558-3220

Address: 28633 Hoover, Warren, MI 48093

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.**

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____