# ORAL & FACIAL SURGERY CENTER OF TALLAHASSEE

Barrett R. Tolley D.D.S.
Oral and Maxillofacial Surgeon

# WELCOME

Please complete the following information:

## PATIENT INFORMATION (*Confidential)*

Legal Name:_____ Date:_____
First M.I. Last Name
Name Preference:_____ Date of Birth:_____ Age:_____ Sex:_____
Address:_____ City:_____
State:_____ Zip:_____ Preferred Email: _____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ Single____ Married____ Divorced____ Other____
Full Time Student?: Yes____ No____ School Name:_____

Employer:_____ Occupation:_____
Social Security Number:_____ DL#:_____
Physician:_____ Dentist:_____
First Last Name First Last Name
Whom may we thank for referring you to us?_____
First Last Name

## EMERGENCY CONTACT INFORMATION

Name:_____ Relationship To Patient:_____

Cell Phone: _____ Home Phone:_____ Work Phone:_____

## DENTAL INSURANCE INFORMATION:

Name of Primary Insurance: _____ Group#: _____
Name of Policy Holder: _____ Policy Holder's SS#: _____
Member ID#: _____ Policy Holder's DOB: _____
Insurance Phone #: _____

## MEDICAL INSURANCE INFORMATION:

Name of Primary Insurance: _____ Group#: _____
Name of Policy Holder: _____ Policy Holder's SS#: _____
Member ID#: _____ Policy Holder's DOB: _____
Insurance Phone #: _____

***(Optional)***
Name of Secondary Medical Insurance: _____ Group#: _____
Name of Policy Holder: _____ Policy Holder's SS#: _____
Member ID#: _____ Policy Holder's DOB: _____
Insurance Phone #: _____

## AUTHORIZATION:

***Please initial by each paragraph and sign below:***

____1. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment, deductible, and any outstanding balance not covered by insurance. I certify that I and/or my dependents am/are covered by the above insurance company(ies), and hereby authorize payment directly to Oral & Facial Surgery Center of Tallahassee, the insurance benefits otherwise payable to me. I hereby authorize the release of any information necessary to my insurance company to secure the payment of benefits, including results of blood test(s) to detect antibodies to the virus that causes AIDS (HIV).

____2. I understand that it is my responsibility to know the plan guidelines of my insurance company. The doctors of Oral & Facial Surgery Center of Tallahassee will recommend treatment based on quality of care for patients, not the standard set by any insurance company.

____3. I understand that the office of Oral & Facial Surgery Center of Tallahassee will duplicate and make available to me at my request any x-rays they have taken for the purpose of my diagnosis. I acknowledge that the office will need a minimum of 24 hours notice for any duplication request. I understand that Oral & Facial Surgery Center of Tallahassee will keep the minimal duplication fee of $10.00 for these x-rays and sign a records release form as required by law.

_____

**Print** Patient's Name (parent or guardian, if minor)

_____ _____

**Signature** of Patient (parent or guardian, if minor) Date

_____ _____

**Signature** of Responsible Party Date

**Please remember to present your DRIVER'S LICENSE (or any form of picture ID), INSURANCE CARDS (If you have insurance), and REFERRAL SLIP to the front desk team.**

**If instructed, please bring extra items such as XRAYs and/or other records to your appointment.**

# FINANCIAL POLICY

Please understand that payment of your bill is considered part of your treatment experience. The following is a statement of our Financial Policy. We **REQUIRE** that you read and sign this agreement.

**You are Responsible for Your Bill**

As the recipient of our services, you are responsible for all charges associated with each of the services you receive during the course of your treatment. For your convenience we offer the following payment methods:

1. Cash, Check, Visa, MasterCard, Discover, and American Express
2. Care Credit – Depending on the amount to be financed, you may be eligible for the 6 month interest free loan. Our office honors the 6 month interest free plan, or the 24, 36, 48, & 60 month plans with interest.

**If You Have Insurance**

If you have dental and/or medical insurance, we will "assist" you in receiving the maximum allowable benefits available under you policy. We will file a claim for services on your behalf, and in most cases we will receive payment directly from your insurance company. We do not file any "secondary" dental insurance you may have but we will certainly give you the proper documentation you would need in order to file the claim yourself. If, we are unable to receive payment for services on your behalf after following normal claim submission procedures, we will expect payment in full from you.

**We Will Collect the ESTIMATED Amount You Will Owe at Your Appointment**

Prior to your appointment we will obtain your insurance benefits based upon the information that you/or your referring physician's office provides us. Depending on your insurance, we will collect on the day of your appointment the amount we ESTIMATE to be your responsibility. Please keep in mind that any payment made is only an ESTIMATE and we cannot guarantee the final payment amount from your insurance. If the doctor performs different or additional procedures, your ESTIMATED fees will change. Also, if lab services for pathology are needed, you will receive a separate bill from that company.

**Unpaid Balances**

All outstanding balances over 90 days without prior arrangements will be subject to collection by an outside agency, which may incur additional fees and adversely affect your credit. I agree to pay attorney fees and costs of suit if legal action is necessary to enforce collection.

**Cancellation Policy**

Because we have allotted time and space for you on our schedule for a given day, we ask that if you need to cancel or re-schedule your consultation appointment for any reason, to please notify us at least 24 hours in advance of your appointment time as a courtesy to our office. Additionally, if you have scheduled your proposed treatment, that you would also give us at least a **72 business hour** notification should you need to cancel or re-schedule to avoid our broken appointment fee of $250.00.

**ASSIGNMENT OF BENEFITS**

I hereby authorize payment of any insurance benefits due me to: Oral & Facial Surgery Center of Tallahassee and/or Barrett R. Tolley, DDS, and authorize release of any information relating to my claim(s) to the insurer and its agents. I also understand that I am ultimately financially responsible to Oral & Facial Surgery Center of Tallahassee for the entire treatment costs.

I have read and understand this Financial Policy and agree to its terms.

_____ _____

Signature of Person Financially Responsible Date

# Oral & Facial Surgery Center of Tallahassee

CONSENT FOR RELEASE OF MEDICAL RECORDS AND
USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, consent to the use or disclosure of my protected health information by the Oral & Facial Surgery Center of Tallahassee (OFSC), in accordance with the Notice of Privacy Practices (NOPP). I have reviewed & upon my request have been given a copy of the NOPP, & also have been given the opportunity to ask questions about it, understand it and do hereby agree to its terms. I understand that diagnosis or treatment of me by OFSC, may be conditioned upon my consent as evidenced by my signature on this document.

**X**_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

Please list the names of any person that you will allow to receive a copy of your medical information.

_____ _____

_____ _____

**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 barrier or Emergency prohibited us from obtaining acknowledgement
- ☐ Other _____

_____ _____
Signature of Privacy Officer or Office Staff Date

## MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

**For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.**

1. Are you in good health? ..... Yes No
2. Have there been any changes in your health during the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? ..... Yes No
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   Please list all medications: _____
   _____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
    b. Rheumatic Heart Disease ..... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. Allergies ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma ..... Yes No
    g. Hay fever ..... Yes No
    h. Fainting spells or seizures ..... Yes No
    i. Diabetes ..... Yes No
    j. Hepatitis, jaundice or liver disease ..... Yes No
    k. Frequent or recurring mouth sores ..... Yes No
    l. Thyroid problems ..... Yes No
    m. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
    n. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
    o. Osteoporosis ..... Yes No
    p. Stomach ulcer or hyperacidity ..... Yes No
    q. Kidney trouble ..... Yes No
    r. Tuberculosis ..... Yes No
    s. Persistent cough or cough that produces blood ..... Yes No
    t. Persistent swollen neck glands ..... Yes No

u. Low blood pressure ..... Yes No
v. Epilepsy or neurological disorder ..... Yes No
w. Cancer ..... Yes No
x. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Food ..... Yes No
    j. Other ..... Yes No

16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
    _____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
18. Do you smoke or chew Tobacco? ..... Yes No
    How much and for how long? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
20. Are you wearing contact lenses? ..... Yes No
21. Are you wearing removable dental appliances? ..... Yes No
22. Do you wish to talk with the doctor privately about anything? ..... Yes No

## Women

20. Are you pregnant or trying to become pregnant ..... Yes No
21. Do you have problems associated with your menstrual period? ..... Yes No
22. Are you nursing? ..... Yes No
23. Are you taking birth control pills? ..... Yes No

**Chief Dental Complaint:** _____
_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient's Signature:_____ Date:_____

Oral & Facial Surgery Center of Tallahassee
Oral & Maxillofacial Surgery
Barrett R. Tolley, D.D.S.

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL 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.**

Florida law and the Health Insurance Portability & Accountability Act of 1996 require us to maintain the privacy of your protected health information (hereafter PHI). We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This notice takes effect September 1, 2007.

Oral & Facial Surgery Center of Tallahassee (hereafter OFSC) considers your PHI confidential and has policies and procedures in place to maintain the privacy of your information. PHI means health information, including my demographic information, collected from me and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me. We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (use computer passwords and change them periodically, limit access to areas where PHI is stored, make efforts to speak softly when discussing PHI with you, etc.).

You will be asked to sign a Consent form and/or an Authorization form when you receive this Notice of Privacy Practices. By signing the consent you release, hold harmless and agree to indemnify the OFSC, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice. 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. The revised Notice will be effective when it is posted in our office. You may request a copy of our Notice at any time.

**USES AND DISCLOSURES OF HEALTH INFORMATION WITH YOUR CONSENT:**

We use and disclose your PHI for treatment, payment, and healthcare operations.

- When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we may use your PHI internally and disclose it to health-care providers such as dentists, doctors, pharmacies, hospitals, laboratories, and other health-care providers providing treatment to you (to form a diagnosis or treatment plan, consult with other providers about your care, call in prescriptions to your pharmacy, arrange appointments with other health-care providers, schedule lab work for you, etc.); insurers, a health-benefits plan, or another third party (to obtain payment for services rendered, confirm insurance coverage, obtain pre-treatment estimates or prior authorizations from your health plan, etc.); government authorities, and their respective agents. These parties are required to keep PHI confidential as provided by applicable law.
- We may use or disclose your PHI to provide you with appointment reminders (such as phone calls, voicemail messages, postcards, or letters). We may leave messages with whomever answers your telephone, but we will not give out detailed PHI. We may also call you by name from the waiting room.
- We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare.
- In addition to the above, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. You may revoke this authorization (in writing) at any time. Your revocation will take effect when we receive it. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.

**USES AND DISCLOSURES OF HEALTH INFORMATION WITHOUT YOUR PERMISSION:**

We may use or disclose your PHI without your permission, Consent or Authorization in the following situations:

- We may use or disclose PHI when we are required to do so by federal, state, or local law.

- We may disclose your PHI when necessary for public health reasons (prevention or control of disease; reporting information such as adverse reactions to anesthesia; ineffective or dangerous medications or products; suspected abuse, neglect, or exploitation of children, disabled adults or elderly, etc.).
- We may use or disclose PHI for judicial, administrative proceedings, and law enforcement purposes (in response to a warrant, subpoena or court order; by providing PHI to coroners and medical examiners to identify deceased persons, etc.).
- We may disclose your PHI for workers' compensation purposes.
- We may disclose your PHI to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We will disclose your information to the extent necessary to avert a serious threat to your health or safety to the health or safety of others.
- We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances.
- In the event of your incapacity or emergency circumstances, we will disclose your PHI based on a determination using our professional judgment disclosing only information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment to make inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

**PATIENT RIGHTS**

- You have the right to view or get copies of your PHI, with limited exceptions. You must submit a written request to obtain access to your PHI. You may obtain a form to request access by using the contact information at the end of this Notice. You will be charged a reasonable cost-based fee ($1/page) for expenses such as copies and staff time and postage if you want the copies mailed to you.
- You have the right to request that we amend your PHI if you think the information we have about you is incorrect, or that something important is missing from your records. Your request must be in writing and must explain why the information should be amended. If we grant your request, we will make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language. We may deny your request under certain circumstances (request does not give reason you want the change, we did not create the information you want changed and the entity that did can be contacted to change it, it was compiled for use in litigation, or we determine it is accurate and complete, etc.). If another doctor involved in your care tells us in writing to amend your PHI, we will do so as expeditiously as possible upon receipt of the changes.
- You have the right to receive a list of those who received your PHI from us for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years (excluding dates before September 1, 2007). Your must submit a written request or complete a form from our office. 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.
- You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by your agreement (except in an emergency). Also, in some circumstances we may be unable to grant your request (e.g., we are required by law; you signed an authorization form that allows us to use or disclose your PHI in the manner you want restricted).
- You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. We will accommodate reasonable requests, which must be made in writing. Your request must specify the alternate means or location, and provide satisfactory explanation how payments will be handled under the means or location you request.

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you are concerned that we may have violated your privacy rights, made a decision about access to your PHI incorrectly, or our response to a request you made to amend or restrict the use or disclosure of your PHI was incorrect, you may contact us using the information below. 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 upon request. Unresolved complaints will be subject to binding arbitration under the rules of the American Arbitration Association in Tallahassee, FL with each party to pay their own attorney's fees and costs. We support your right to the privacy of your PHI. 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.

Provider Contact Office: Oral & Facial Surgery Center of Tallahassee
Contact Person: OFSC Representative
Address: 3330 Capital Oaks Drive Tallahassee, FL 32308
Telephone: (850)386-4602