William E. Carroll Jr., D.D.S.

1620 MULKEY ROAD, SUITE 200 AUSTELL, GEORGIA 30106 (770) 941-5111

WELCOME TO OUR OFFICE

Thank you for choosing us to assist you in the maintenance of your dental health. We are committed to providing you with the best possible care. It is our goal to provide each patient with the best dentistry our industry has to offer. Your needs are of primary importance to our staff.

PAYMENT POLICY

If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our policies.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express, and Discover.

We may accept your insurance on the first visit date only if you have proper identification, an insurance card or form, social security number, and group number. We must be able to verify your coverage and benefits before accepting insurance on the first visit date. If we accept your insurance, you must pay your deductible plus your portion of the total charges at the time of services. If your insurance company has not paid the full balance within 45 days, you have 15 days to pay the balance. A finance charge of 1.5% will be added to unpaid accounts after 30 days.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

2. We file insurance claims as a courtesy to our patients at no charge. We will not become involved in any disputes between you and your insurance company.

3. All insurance benefits are not a guarantee of payment. We can only estimate approximately what your insurance company may pay according to information given. You are responsible for your bill not your insurance company.

Please read about our broken appointment policy

Unless cancelled at least 24 hours in advance, our policy is to charge a minimum of $25.00 for missed appointments. We try to call everyone to confirm appointments ahead of time, but please do not count on this courtesy, as you are responsible for keeping up with your appointment time and date. You may call the office to confirm your appointment if you are unsure of the date or time.

Patient Signature______________________________ Date ______________

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All co pays and estimated portions are due at the time services are rendered. YOU are ultimately responsible for your bill and any costs that are not covered or payable by your dental benefits carrier. We will glady file your claims for you and help you maximize your benefits. Please note that all implant, cosmetic cases, and sleep studies must be paid in full up front before treatment is started. This is to cover the cost of implant parts and any lab fees associated with your individualized case. If you need financing, we offer CareCredit and you may apply by calling 1-800-365-8295 or you may apply online at CareCredit.com. Brochures are located at front desk. We accept cash, checks, Visa, MasterCard, Discover, and American Express.

Patient Signature and Date______________________________________

PATIENT INFORMATION FORM

TODAY'S DATE ____________________

PATIENT NAME (LAST - FIRST - MIDDLE)	DATE OF BIRTH	AGE	MARITAL STATUS S ☐ M ☐	DRIVERS LIC. NO.

ADDRESS (STREET - CITY - STATE - ZIP)	HOME PHONE ( )	HGT.	WGT.	EYE COLOR

NAME OF EMPLOYER	OCCUPATION	WORK PHONE ( )	EXT

EMPLOYER ADDRESS (STREET - CITY - STATE - ZIP)	LANDLORD	LANDLORD PHONE ( )	SOCIAL SECURITY NO.

SPOUSE'S NAME (LAST - FIRST - MIDDLE)	DATE OF BIRTH	NAME OF EMPLOYER	WORK PHONE ( )

GUARANTOR NAME	DATE OF BIRTH	SOCIAL SECURITY NO.	HOME PHONE ( )

GUARANTOR ADDRESS (STREET - CITY - STATE - ZIP)	WORK PHONE ( )

GUARANTOR EMPLOYER	OCCUPATION

NEAREST FRIEND NOT LIVING WITH YOU	PHONE NO. ( )	NEAREST RELATIVE NOT LIVING WITH YOU	PHONE NO. ( )

IN CASE OF EMERGENCY CONTACT > NAME	RELATIONSHIP	PHONE NO. ( )

WHOM MAY WE THANK FOR REFERRING YOU TO US?	FAMILY PHYSICIAN	PHONE NO. ( )	FAMILY DENTIST	PHONE NO. ( )

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?	I WILL BE PAYING TODAY BY ☐ CASH ☐ CHECK ☐ CREDIT CARD

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE NO. ( )
NAME OF INSURED	RELATIONSHIP	I.D. NO.	GROUP NO.
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE NO. ( )
NAME OF INSURED	RELATIONSHIP	I.D. NO.	GROUP NO.

CHIEF COMPLAINT

Please provide us with your email address ____________________

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional 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 health status or the above information.

____________________ Date ____________
Signature

____________________ Date ____________
Signature

MEDICAL HISTORY

PATIENT NAME ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No ◯ N/A ______________________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A ______________________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A ______________________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ◯ N/A ______________________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ◯ N/A

Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Are you on a special diet? ◯ Yes ◯ No ◯ N/A

Do you use controlled substances? ◯ Yes ⊙ No ◯ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other ______________

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pacemaker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A ______________________________

Comments: ______________________________

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

WILLIAM E. CARROLL, JR., D.D.S.
1620 MULKEY ROAD, SUITE 200
AUSTELL, GEORGIA 30106
(770) 941-5111

Privacy Officer: JEANNIE MYERS **Effective Date: APRIL 01, 2003**

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

FORM 194232 N/02/13 ITEM 8101

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Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

William E. Carroll Jr., 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.

WILLIAM E. CARROLL JR., D.D.S., PC
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: ____

ADDRESS: ____

TELEPHONE: ____

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, 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 revision of our Notice, at any time by contacting.

Contact Person: Jeannie Myers

Telephone: (770)941-5111 Fax: (770)941-4200

Address: **1620 Mulkey Rd. Ste 200 Autell, GA. 30106**

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of you 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: ____________________________