SAMSON DENTAL ASSOCIATES, LLC

Consent for Treatment

I hereby authorize Samson Dental Associates (SDA) to take X rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental health needs. I also authorize SDA to perform all recommended treatment and to administer the appropriate medications and or anesthetic mutually agreed upon. I understand that using anesthetic agents is optional and using them involves certain risks, such as, but no limited to, hematoma, paresthesia, trismus, or increased heart rate. It is my responsibility to notify your office of any health changes and or any medications currently being used. I will be given an opportunity to discuss any concerns or questions that I may have.

_____ _____

Signature Date

Financial Responsibility

I understand that I am financially responsible for all charges in this office. All charges will be paid in full at the time of service unless written financial agreements were made in advance. **I understand that this office cannot guarantee coverage from my insurance company therefore I will be fully liable for all treatment rendered. Any courtesies given to patient by doctors are valid for 24 hours.** I agree to pay collection costs (40%), attorney fees, and any other costs that may be incurred to enforce collections of any outstanding amount. We reserve appointments especially for you. If you are unable to keep your scheduled appointment, please inform us within 48 business hours or there may be an $85.00 fee (with exceptions of emergencies). In the event you choose **not to show, there will be an $85.00 fee applied per hour of scheduled time**. For your convenience, we gladly accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CARE CREDIT. Financing options will be considered.

_____ _____

Signature Date

SAMSON DENTAL ASSOCIATES, LLC
Dr. David Samson, DMD

PATIENT ACKNOWLEDGEMENT FORM

Use and Disclosure of Protected Health Information

Samson Dental Associates LLC "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge that our office's "Notice of Privacy Practices" located in our reception area. Our "Notice of Privacy Practices" states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail or at your next visit.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

_____ _____

Signature Date

Dental Insurance

There are over 3,000 different types of dental insurance plans. We do our best to help you understand and work with your insurance policy, find out the allowed maximum and deductibles and eligibility services. At Samson Dental, we gladly submit your insurance claims for you and will fully attempt to help you receive full insurance benefits. However, **you are ultimately responsible for payment of the services provided. All claims must be paid within 30 days** by your insurance program. You may be asked to call your insurance carrier to ensure the insurance company has your claim and will pay a benefit. Please remember that an insurance policy is a contract between you, and your employer and the insurance company, and we have no direct relationship with them. Because policies can change every year when contracts renew, often without clear communications, we encourage our patients to become familiar with their insurance coverage, and to notify our office of any changes. We also recommend that our patients take the time to understand which policy they are selecting during open enrollment period. Changes in eligibility, maximums, or covered benefits could result in unexpected out of pocket costs. **Ultimately, all charges for services are your financial responsibility.**

_____ _____

Signature Date

TIME 01:00 PM

DATE 6/1/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred by

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: [redacted] Birth Date: [redacted] Date Created: [redacted]

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	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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 ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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:

X Date:_____

David S. Samson, DMD

Notice of Privacy Practices

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information:

We use heath information about you for treatment, to obtain payment and for health care operations, including administrative purposes and evaluation of quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Example of Treatment, Payment and Health Care Operations:

Treatment: We will use and disclose your health information to provide you with medical treatment or services. We may disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions and to family members who are helping with your care.

Payment: We may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to assess the care and outcomes of your case and others like it.

Special Uses: We may use your information to contact you with appointment reminders. We may do this by way of an answering machine or one who answers your telephone.

Other Uses and Disclosures: We may use and disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required to report gunshot wounds, suspected abuse or neglect, similar injuries and events.

Research:

We may also use or disclose information for approved medical research.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights:

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but, if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards or phone/ voicemail to remind you of your appointments/results.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that the information in your record is incorrect, or, if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accountings of Disclosure: You may request a list of institutes where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Complaints:

If you are concerned that we have violated your privacy rights, or, if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person:

If you have any questions, requests or complaints please contact:

Office Manager

1116 West Street
Annapolis, Maryland 21401
410-268-7737

NO DENTAL INSURANCE? NO PROBLEM! ☺

Check out our In-House Program!

VIP SMILE PROGRAM

Because preventative care will save you time and money in the long run.

Our VIP SMILE program is a great solution for patients who do not have dental insurance. Our mission is to encourage those without dental insurance to undergo preventative dental care in the hopes of avoiding major problems before they occur. Also, a 20% savings provided in the event that dental work is needed.

Unlike most of today's dental insurances, our program has no maximum limits, no waiting periods, no deductibles, and no pre-approval! Since the program is provided "In-House" there's no need to contact a third party to determine benefits or navigate confusing insurance rules.

What's included: Two routine cleanings in a 12 month period, two doctor examinations, one necessary set of x-rays per year, Oral Hygiene instructions, pediatric fluoride treatments, and your 20% savings on recommended restorative care beyond the items listed.

Stipulations:

Membership is due in full upon joining and all payments for restorative care due in full when services rendered. The VIP SMILE Program cannot be combined with dental insurance. Dental services must be completed within the 12 month membership period. Renewal payment due 12 months from initial sign up date. Members can opt out any time. Benefits only apply to services rendered at Annapolis Family Dental.

_____ _____

Signature Date

_____

Printed Name