REFRESH DENTAL
BERKELEY, CALIFORNIA
EST. 2012

3031 TELEGRAPH AVE. #136
BERKELEY, CA 94705

T: 510-845-2240
F: 510-845-2273

PATIENT INFORMATION

We are pleased to welcome you to Refresh Dental. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:

Refresh Dental's Schedule Policy

Here at Refresh Dental, we go to great lengths to reserve your appointment time in our schedule to ensure that you receive our undivided attention during your scheduled appointments and treatment.

We understand life has its unexpected moments and we wouldn't want to penalize you for those unforeseen events. Therefore, we simply ask you to arrive on time to ensure that enough time is allowed for your scheduled appointment or call us at least 24 business hours prior to your appointment to make any changes, reschedule or to cancel.

- If you are more than 15 minutes late for your appointment, your appointment may be rescheduled at the office discretion.
- If you need to reschedule a routine cleaning and exam appointment but fail to let us know within 24 business hours or don't show-up to your scheduled appointment, a $35 fee will be enforced
- If you need to reschedule an appointment for treatment such as fillings, deep cleanings, crown, bridges, extractions, but fail to give us a 24 business hour advance notice or don't show-up to your scheduled appointment, a $50 fee will be enforced

****Please note that Saturday's and Sunday's are not considered working days****

X _____

Patient Signature & Date

ACKNOWLEGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

******You May Refuse to Sign This Acknowledgement******

I_____, have read and received a copy of the office's Notice of Policy Practices.

_____

Patient Name (printed)

_____

Signature of patients (Guardian)

_____

Date

Notice of Privacy Policies

This 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 IS IMPORTANT.

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's. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/1/2013, 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 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 and received before we made changes. Before we make a significant change on our privacy practices, we will change this notice and make the New Notice available upon request.

USES AND DISCLOSURES OF HELATH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: *We may use and disclose your health information to a physician or other healthcare provider providing you treatment.*

PAYMENT: *We may use and disclose your health information to obtain payment for services we provided you.*

Healthcare Operations: *we may use and disclose your health information in connection with our health care 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. I you give us an authorization; you may revoke it in writing at any time. Your revocation will not affect any use or disclosure your health information for any reason except those described in this Notice.*

TO YOUR FRIENDS AND FAMILY: *We must disclose your health information to you, as described in 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 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 opportunity to object to such uses or discloses. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional's 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 experiences 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 for marketing communications without your written authorization.*

ABUSE OR NEGLECT: *We may disclose your health information to appropriate authorities if we 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.*

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 the format other that 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 $2.00 for each copy, $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 alternate format, we will charge cost based fee for proving your health information in that format. If you prefer, we will prepare an explanation of your health information for a fee. Contact us using information listed at the end of this Notice for a full explanation of our fee structure.)

Restrictions: *You may have the right to request that we place additional restrictions on 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 12month period, we may charge you a reasonable cost based fee for responding to these additional request.*

ALTERNATIVE COMMUNICATIONS: *You may have the right to request that we communicate with you about your health information but alternative means or alternative locations. (You must make a request in writing*

Alternative Communications: You have the right to request that we communicate with you about your health information alternative locations. (You must request in writing) Your request must specify your 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 what the information should be amended.) We may deny your request under certain circumstances.*

ELECTRONIC NOTICE: *If you receive this Notice on your Web site or by electronic mail (Email), 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 a communicate with you by alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complain to the U.S. Department of Health Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health Services.

Refresh Dental Group
3031 Telegraph Ave #136
Berkeley, CA 94705