JOHN F RINK

DDS, AAACD

CHARLESTON CENTER FOR COSMETIC AND
RESTORATIVE DENTISTRY

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

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.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATIONABOUT 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, letters, emails or texts).

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 $.50 for each page, $20.00 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 also may 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 Officer: ***John F. Rink, DDS***

Telephone: ***(843) 766-1132*** Fax: ***(843) 763-7299***

E-mail: ***info@cccrdentistry.com***

Address: ***33 C Gamecock Avenue, Charleston, SC 29407***

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
Patient Name (please print)

Privacy Practices.

_____
{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)

_____

_____

JOHN F RINK

DDS, AAACD

CHARLESTON CENTER FOR COSMETIC AND RESTORATIVE DENTISTRY

Patient Name:_____Patient's Date of Birth:_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

The following family members, friends or other person(s) may receive this patient information:

_____

Specific description of the patient information being disclosed includes but is not limited to treatment history, planned treatment, financial history and appointments.

_____

I authorize the following person(s) (Office Staff Member) to make this use or disclosure:

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at Charleston Center for Cosmetic & Restorative Dentistry, LLC, John F. Rink, DDS. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs:

_____

Signature of Patient or Patient's Personal Representative:

_____Date_____

JOHN F RINK

DDS, AAACD

CHARLESTON CENTER FOR COSMETIC AND RESTORATIVE DENTISTRY

Welcome to your new dental office. Our commitment is to provide you with personal care utilizing the best possible preventive and cosmetic dental techniques. Please take time to carefully complete the following information.

Name_____ Nickname_____ Date_____

Address_____City_____State_____Zip_____

☐ Home Phone _____ ☐ Work Phone _____ ☐ Cell Phone_____

(Please mark all that apply). Sex: M___ F___ Marital Status___ Birthdate_____Age___ SS#_____

Driver's license number_____ E-Mail Address_____

Would you like to receive appointment or other reminders via text messages? **Y/N** Email? **Y/N** Email Newsletters? **Y/N**

Patient Employed By_____Occupation_____

Spouse Name_____Occupation_____

Spouse Birthdate _____Spouse Cell #_____Spouse Work #_____Spouse SS#_____

In Case of Emergency Contact_____Phone_____Relationship_____

DENTAL INSURANCE INFORMATION

Name of Insured_____SS#_____Birthdate_____

Insured's Employer_____

Dental Insurance Company Name_____Address (CSZ)_____

Phone_____ Subscriber ID#_____Group#_____Policy#_____

ADDITIONAL DENTAL INSURANCE

Name of Insured_____SS#_____Birthdate_____

Insured's Employer_____

Dental Insurance Company Name_____Address (CSZ)_____

Phone_____ Subscriber ID#_____Group#_____Policy#_____

***How did you hear about us*?** Another patient? _____ If so, who may we thank for the referral?_____

Website?___ Google search?___ Other search engine?___ Print ad?___ Dental/Medical Professional?____

Professional's Name?_____ Other Referral?_____

Please tell us about your hobbies and interests:_____

_____

Purpose of today's visit_____

List any previous major dental treatment_____

Date of last dental exam_____ Date of last full mouth x-rays_____ Name of previous dentist_____

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
Please include OTC products, vitamins, herbs & supplements _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No

Are you…

- **Taking medications for bone density or osteoporosis such as Fosamax, Boniva, Actonel, Zometa, Didronel, Relcast, Adasta, Atelvia, Aredia, Binostro, Skelid, or other? YES ___ NO ___**
- **Pregnant/Trying to get pregnant? YES ___ NO ___**
- **Taking oral contraceptives? YES ___ NO ___**

Are you allergic to any of the following (Circle)? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Do you use controlled substances? Yes No _____

Other Allergy *(Please include foods).* If yes, please explain: _____

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 Problem	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 Pace Maker	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									

Other:_____

Have you ever had any serious illness not listed above? Yes____No_____If yes, please explain: _____
Do you have discomfort with your teeth, jaw or ear?_____ Do you have discomfort, sores or lumps in your head or neck?_____
Do you floss?_____ How often?_____ Are you very nervous about having dental treatment?_____
Have you had a traumatic dental experience?_____ When/How?_____
What is the condition of your parent's oral health?_____
Are you interested in saving your teeth?_____ Do you feel you chew efficiently?_____ Do you clench or grind your teeth?_____
Are you concerned about finances needed to return your mouth to health?_____
Are you frustrated because you are always having dental work every time you come to the dentist?_____
On a scale of 1 (lowest) to 10 (highest), how would you rate the appearance of your smile?_____
I think my present state of dental health is: _____excellent_____good_____poor
I would like my dental health to be: _____excellent_____good_____poor
If by magic I could change anything about my teeth, it would be: _____

I hereby state that the answers to the questions above are correct to the best of my ability. I furthermore promise to take it upon myself to inform this office of any change in my medical history prior to subsequent dental treatments. I also give my consent for medical and dental professional consultation in regards to my medical or dental history and/or treatment I understand that I am financially responsible for all charges, regardless of any insurance involvement. I agree to pay all collection or legal fees, including interest charges associated with obtaining payment for the outstanding balance.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Financial Policy

We are committed to providing you with excellent preventive, restorative, and esthetic dentistry. The following is a statement of our financial policy. We request that you read, agree to and sign prior to any treatment.

Method of Payment
Payment is due before or upon the day a service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and American Express. Outside financing is available upon request and approval.

Fees for Services
All charges you incur are the responsibility of the patient or responsible party of the patient. Payment in full is due before or upon the initiation of major treatment. We require a minimum deposit of 50% in order to reserve an appointment for major services, (crowns, 3/4 crowns, implant supported dentistry, veneers, etc.). If you are taking advantage of the financing program, please contact our office so we may verify the account holder information.

Insurance
We are **not** network providers or preferred providers for any insurance companies or networks. If you have a dental insurance policy, as a courtesy, we will file your dental insurance claims for you. Any benefits allowed will be reimbursed to the subscriber of the policy. Please contact your insurance company for a detail of your benefits.

Minors accompanied or unaccompanied by the parent or legal guardian
The parent or legal guardian accompanying a minor, or sending an unaccompanied minor, who has consented to treatment is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment.

Consent
I have read, understand and agree to the above terms and conditions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

Patient /Parent name printed

_____

Patient /Parent signature and Date

_____

RELEASE AND PHOTO IMAGE PUBLICATION CONSENT VERIFICATION AGREEMENT

This AGREEMENT is for the purpose of identifying any express or implied agreement, including, but not limited to, permission, consent, release, and/or authorization between doctor and patient in connection with the professional services patient received from doctor, and/or doctor's associate(s).

Doctor and patient warrant and represent that patient has given consent and full authorization for use of any photographs and/or images of patient, under the following conditions:

1. The photographs and/or images will be/have been taken by the doctor, doctor's associate or by a professional photographer and/or a skilled operator approved by doctor.

2. The photographs and/or images shall be used for the purpose of medical/dental education via speaking engagements/lectures to professional groups in the interest of medical/dental care. The photographs/images may also be used for dental laboratory communication. They may also be used for advertisement and/or education via media such as website, print or television.

3. At no time will patient's name, address, or any other alpha/numeric patient-identifiable information be used in connection with the use of the photographs and/or images of patient. Patient acknowledges the incidental possibility that his/her identity may become known as a result of the use of the photographs and/or images described above.

4. Patient's photographs and/or images shall not be used for any express purpose other than described above.

By signing below, patient certifies that he/she has read and understood each and every section of this Agreement, and agrees to be bound by its terms.

_____ PATIENT (Signature)

_____ PATIENT (Print)

_____ DATE

_____WITNESS on behalf of DENTIST