Brent Pennington, DMD, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE 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 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 (MM/DD/YR), 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, or letters).

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 **$0.10** for each page, **$10.00** 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: **Allison Jones** Telephone: **(706) 935-2900** Fax: **(706) 935-2904**

Address: **37 Gateway Business Park Dr. Ringgold, GA 30736**

Pennington Dental Center

Notice of Privacy Practices

We are required by applicable federal and state law to maintain the privacy of of your health information. We are also required to give you this Notice about out privacy practices our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect February 21, 2005 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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 copies of Notice at any time. For More information about our privacy practices or for additional copies of the Notice, please contact us 706-935-2900.

Acknowledgment of Receipt of Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices for Pennington Dental Center.

Print Name: _____

Signature: _____

Date: _____

Pennington Dental Center

Medical Health History

Patient Name: _____ DOB: _____ Date: _____

Date of last health care exam by a medical doctor: _____ What was exam for: _____

Have you been hospitalized in the last 5 years? (Please Circle) No Yes For What? _____

Are you currently receiving medical care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____ 2. _____

For the following questions circle yes or no if you have ever been diagnosed, or treated in the past, or are now being treated for, or are aware of any of the following. **Your answers are for our records only and will be confidential.** *Please note that during your initial visit you will be asked some questions about your response. Our team may as additional questions concerning your health.*

Anemia or Blood Disorder	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Joint Replacement Year placed	No	Yes
Asthma	No	Yes	Kidney Disease or Problems	No	Yes
Inhaler, Advair, Breathing Treatments	No	Yes	Liver Disease (including Jaundice) or Problems	No	Yes
Cancer or Tumor Year	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes (HbA1C #)	No	Yes	Numbness in feet or toes	No	Yes
Emphysema or other Respiratory/Lung Illness	No	Yes	Previous Biopsies Year	No	Yes
Epilepsy	No	Yes	Radiation or chemotherapy Treatment Year	No	Yes
Glaucoma/Eye Problems	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Sexually Transmitted Condition	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Heart murmur/Irregular Heart Beat	No	Yes
Heart Stent Year Placed	No	Yes	Rheumatic Fever	No	Yes
Coumadin/Blood Thinners	No	Yes	Recurrent Illness	No	Yes
Depression/Panic Attacks/Mood Swings	No	Yes	Migraine/Severe Headaches	No	Yes
Sleep Difficulties/Sleep Apnea	No	Yes	Stomach Ulcers/Problems/Reflux	No	Yes
High Blood Pressure	No	Yes	High Cholesterol	No	Yes
Mitral-Valve Prolapse	No	Yes	Previous Alcohol or Drug Abuse/Addiction	No	Yes
Fainting or Dizzy Spells/Angina	No	Yes	Psychological issues/Post Traumatic Stress	No	Yes
Blood Transfusion Year	No	Yes	Abnormal Bleeding from a cut	No	Yes
Leukemia	No	Yes	Thyroid Problem	No	Yes
Cardiac Pacemaker	No	Yes	Joint Replacement, implant, pins, plates or screws	No	Yes
Angina, Chest pains	No	Yes	Stroke	No	Yes
Tuberculosis	No	Yes	Respiratory Problems	No	Yes
Hay Fever, Allergies	No	Yes			

Do you have or have you had any other diseases, conditions or medical problems NOT listed on this form?

Have you ever received a diagnosis of "high blood pressure"? No Yes
What is your normal blood pressure? _____/_____ **Today:** _____/_____
Height: Weight:

Are you taking any of these medications?

Pre-Medication before dental treatment	No	Yes	Tagamet (cimetidine) or Prilosec (omeprazole)	No	Yes
Antacids (Pepsid AC, etc)	No	Yes	CadiZem (dilitiaZem) or Calan, Isoptin (Verapamil)	No	Yes
Barbiturates (any)	No	Yes	Diflucan (fluconazole) or Sporonox (itraconazole)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Biaxin (clarithromycin), Erythromycin	No	Yes
Lunesta, Ambien	No	Yes	Tetracycline,Doxycycline	No	Yes
Dilantin or Tegretol	No	Yes	Serzone (nefazodone)	No	Yes
Do you consume grapefruit juice, grapefruit extract	No	Yes	Have you ever taken any prescription drugs such as fen-phen for weight loss	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Acotonel, Boniva) If so, when did the treatment begin: When did treatment end:				No	Yes

List any medications (prescription, over the counter, herbal) taken on a daily basis:

Women:

Are you Pregnant?	No Yes	Your Due date:
Are you a nursing mother?	No Yes	
Are you using any birth control contraceptives? (pills, injections/shots, IUD (Mirena)	No Yes	

Are you allergic or have you had a reaction to:

Local anesthetics	No	Yes	Codeine, Valium, or other sedatives	No	Yes
Penicillin or other antibiotics	No	Yes	Latex or Metals	No	Yes
Aspirin, Ibuprofen or Tylenol	No	Yes	Sulfa Drugs, Iodine	No	Yes
Other (please specify)					

Do you use tobacco No Yes If yes, type: smoke chew dip How much per day How long

I understand that scheduled times are appointed to provide quality care for our patients. Therefore, it is important for me to maintain my scheduled appointments. And, that this office reserves the right to charge for appointments cancelled or broken without 24 hour advanced notice. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. Returned checks and balances over 30 day will be subject to finance charges and possible late fees. I understand balances older than 60 days may be subject to reasonable additional collection fees. Returned checks and balances over 90 days will be turned over to a collection agency unless other arrangements are made with our office. Fees will be added by the out side collection agency used by Brent Pennington DMD,LLC to assist in collecting past due accounts.

_____ _____ _____

Patient (Print Name) Patient Signature Date

Recall Review:

1. Patient's signature: _____ Date: _____
2. Patient's signature: _____ Date: _____
3. Patient's signature: _____ Date: _____
4. Patient's signature: _____ Date: _____

Patient Information **Today's date:**

Patient Name: Birth Date:

Gender (M/F) Social Security #: Marital Status: Driver's License#:

Home Address:

City,State,Zip

Phone #'s: Home: Work: Cell:

Employer/School: Employer/School

E-Mail address:

Person to contact in case of emergency:

***Referral Information*:**

Who may we thank for referring you to our office:

***Spouse,Parent, or Responsible Party Information*:**

Name: Social Security:

Gender (M/F) Marital Status: Birth Date: Driver's License #:

Home address:

City,State,Zip:

Employer: Phone #:

Phone #'s: Home: Work: Cell:

E-Mail address:

Method of Payment: Cash VISA/Mastercard Discover American Express CareCredit
(We no longer accept checks)

Insurance Information

Primary Insurance Plan name and address:

Name of Insured Person: Birth Date:

Insured's home address: City,State,Zip

Insured's Employer: Address:
Patient's relationship to insured: Self Spouse Child Other Insured's Social Security #:

Secondary Insurance

Insurance Plan Name and Address:

Name of Insured Person: Birth Date:

Insured's home address: City,State,Zip

Insured's Employer: Address:

Patient's relationship to insured: Self Spouse Child Other Insured's Social Security #:

Insurance Plan Name and Address:

**We need a copy of all insurance cards and Photo ID (Parent's ID if patient is a minor)

MEMBERSHIP ACCESS PLAN

We want to make quality dentistry more affordable and easier to access with our in-office **MAP (Membership Access Plan)** Dental Discount Program. The **MAP (Membership Access Plan)** is exclusively designed for those individuals and families without dental insurance. Individual and family purchase of the **MAP (Membership Access Plan)** includes some initial and basic dental services for **free** with a small annual membership fee. In addition, with the **MAP** (Membership Access Plan), we are able to offer our members more complex dental services at a reduced rate of **10%-50% off** regular prices. If you have any questions about our **MAP** (Membership Access Plan) -- Dental Discount Program call **706-935-2900** and ask for one of our **MAP-- Navigators** so they can help you **MAP** out your path to good dental health. Let us "*Give you something to smile about*".

With Your MAP (Membership Access Plan)

~ No Annual Maximums
~ No Deductibles
~ No Claim Forms
~ No Waiting Period (Immediate Eligibility)
~ No Pre-Existing Condition Limitations
~ No Preauthorization Required

Annual Cost:

Individual $150.00
Dual * $210.00
Family ** (Dual $210.00) + $100.00/person (max 4 additional family members)
*Dual Plan is for Parent/Child or Spouse/Partner only
**Family Plan includes Dual Plan and up to 4 children who are enrolled full-time in college until the age of 22, or children who are not enrolled full-time in college until age of 18.

Free Initial Services with Membership

~ Initial X-rays
~ Cleaning
~ Comprehensive Doctors Exam

Program Exclusions and Limitations:

The **MAP** (Membership Access Plan) is a dental discount plan, not insurance. It should not be construed or considered dental insurance. The **MAP** (Membership Access Plan) is administered and honored by **Dr. Brent Pennington DMD, LLC** only and is not valid at any other dental clinic. The **MAP** (Membership Access Plan) ***cannot be used***:

~ In conjunction with another dental plan
~ For services following any type of injuries where a lawsuit, medical insurance, car insurance, disability insurance, or workers compensation insurance are involved
~ For treatment, based on sole opinion of the dentist, that lies outside the realm of his or her capability
~ For referrals to specialists
~ For dental treatment already in progress
~ In conjunction with another dental plan, cash discount, coupon, or discounts that may be offered

MAP (Membership Access Plan) Guidelines:

~ Membership is effective for 3 years from that date you finalize enrollment fee payment
~ Membership fee is NON-REFUNDABLE
~ No refunds/premiums will be issued at any time if participate decides not to utilize the **MAP** program
~ Membership is not transferable to another person
~ Patient's portion of bill is due on day of service
~ Any services received that are not paid for at the time of service will be billed at the usual, higher fee
~ There will be a $25.00 broken appointment fee without 24 hour notice of scheduled appointment time that will have to be paid prior to rescheduling
~ A second broken appointment without 24 hour notice nullifies participation in the MAP program and all fees are forfeited
~ Doctor has the right to change regular price fees as needed
~ The MAP program is subject to change yearly at Doctor's discretion

Fees

List of regular and MAP fees can be viewed by patients upon request. No copy of fees will be given out to patients except with individual treatment plans that have been discussed with doctor.

Renewal Date

_____

*Membership must be renewed 3years. from the date above

Member Names:

_____
_____
_____
_____
_____
_____