Carpenter Dental
(605) 342-5995
(866) 463-9628
5610 Bendt Drive
Rapid City, South Dakota
577029534
USA
office@carpenterdental.net

May 15, 2023

1. C - New Patient - Adult

First name - Patient
.

Last name - Patient
.

Nickname/Preferred name
-

Gender
Other

Patient date of birth
-

Social Security number
-

☐ Were you referred to this office?

-

Contact Information

Home #
-

Mobile #
-

Email address
-

Patient mailing address
, SD, US
-

Emergency Contact

Emergency contact
-

Emergency #
-

Work Information

Employer
-

Employer phone #
-

Employer Address
-

Privacy Policy Consent

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES:

We at Carpenter Dental understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 04/22/22 and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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.

Type name here if you read, understand and agree to the terms and conditions of this Privacy Policy Consent

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USES AND DISCLOSURES OF HEALTH INFORMATION

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

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment for Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 another 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, Xrays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers compensation, law enforcement, and other government requests: We can use or share health information about you:
- For workers compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

Type name here if you read, understand and agree to the terms and conditions of this USES AND DISCLOSURES OF HEALTH INFORMATION

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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, mailing, 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 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 at 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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Crystal Barber
Telephone: (605)342-5995
5610 Bendt Drive
Rapid City, SD 57702

FINANCIAL AGREEMENT

Thank you for choosing Carpenter Dental as your family's comprehensive dental healthcare provider. In order to keep your dental cost as low as possible and help reduce our administrative costs, we require payment at the time a dental service is provided. Our goal is to provide affordable dental services without unnecessary financial stress.

PAYMENT OPTIONS:

1. Cash/Check--This includes money orders.
2. Credit Cards--For your convenience, we accept all major credit cards for payment.
3. Care Credit--For our patients who will need to make payment arrangements for their healthcare needs, we offer Care Credit (upon credit approval). With Care Credit you can enjoy these benefits:
4. Up to 12-months interest free financing
5. Flexible financing options
6. No annual fees or prepayment penalties

1. Insurance Co-Payment. We are a Delta Dental preferred provider. We are more than happy to help you maximize any insurance benefits that may reduce your payment portion for dental treatment. The total cost of your treatment may not be covered by your dental insurance.

I understand that Carpenter Dental cannot guarantee what my insurance will pay and there may be a remaining balance owed by me.

I understand that Carpenter Dental will file my insurance as a courtesy to me and full payment is ultimately my responsibility.

Type name here if you read, understand and agree to the terms and conditions of this Financial Agreement

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. my dental office offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use
email for these purposes. My dental office will use reasonable means to protect the security and confidentiality of email information sent and received. However, my dental office cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential
information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between my dental office and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by My dental office.

Type name here if you read, understand and agree to the terms and conditions of this Email Consent Form

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. My dental office offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. My dental office will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, my dental office cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between my dental office and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by my dental office.

Type name here if you read, understand and agree to the terms and conditions of this Text Message to Mobile Consent

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Form History

✓ Completed	May 15, 2023 07:32:04 MDT	The form has been completed