Hill Country Periodontics, P.A.
Daniel S. O'Dell, D.D.S., M.S.
Practice Limited to Periodontics and Dental Implants
Diplomate of the American Board of Periodontology

400 W. San Antonio St., San Marcos, Texas 78666
(512)-396-2266
FAX: (512)-396-2271

WELCOME TO OUR OFFICE

We welcome you as a patient and appreciate the opportunity to provide you with periodontal services. The information in this packet is designed to help you as a new patient to our office.

We want you to know about our methods of practice and office policies, because the more you know, the more we can be of service. If you have questions not answered here, please ask since we are here to help you.

OUR OFFICE MISSION

Our office is sincerely dedicated to providing the highest level of periodontal care. Our goal is to serve patients in a courteous, professional, and kind manner. It is our intent to serve the total person through concern, care, and personalization through the development of excellent relationships with our patients. Our goal is to improve the quality of our patient's lives by helping them realize the value of their oral condition. This can be accomplished with thorough and complete examinations and treatment planning that offers each patient state of the art care. Also, each patient should be helped to acquire the knowledge and skill necessary to enjoy a healthy mouth, teeth, and periodontal tissues for the rest of their lives.

Please complete the attached forms and bring with you to your consultation:

- **Patient Information form (includes a Dental and Medical history.** Please print, complete both sides of the Patient Information form and bring with you to your appointment.
- **Our Dental Insurance information and Office Policy.** Please print, initial and sign and bring with you to your appointment.
- **Authorization to Release & Discuss Dental Information.** Please print, complete and sign and bring with you to your appointment.
- **Our Notice of Privacy Practices** -Prior to your first visit, please read our Privacy Practices.

If you have any questions please contact our office. We are looking forward to seeing you soon.

Sincerely,

Daniel S. O'Dell, D.D.S., M.S. and Staff

Authorization for Use or Disclosure of Health Information

I, _____, hereby authorize Hill Country Periodontics

to either use the following health information or disclose the following information to:

Name and address of organization to use or receive information:

_____

_____

_____

Describe information to be disclosed
Describe the information to be used or disclosed, such as type of service provided, date of service, and level of detail to be released.

_____

_____

_____

Purpose of each disclosure: _____

_____

Expiration date _____

This authorization shall be in force and effect until the above date, at which time it will expire. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Privacy Officer: Dr. Daniel S. O'Dell, D.D.S., M.S.

Office address: Hill Country Periodontics
400 W. San Antonio St.
San Marcos, TX 78666

I understand that:

- A revocation does not effect health information already sent out under the Authorization.
- My treatment, payment, enrollment or benefits will not be based on whether I provide authorization for the requested use or disclosure.
- That there is a potential for my Protected Health Information to be re-disclosed by the recipient.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of Patient or Personal Representative Personal Representative's Authority

Hill Country Periodontics Insurance Disclaimer

(Please read carefully)

Please note we do not accept nor participate with any DMO/HMO insurance plans, prepay plans, Medicaid or discount plans.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, it is not a guarantee. If you need **exact** payment of benefits, then a pretreatment is required. If you would like this done, you must specify to the office manager **before** any work is initiated.
(This takes 6-8 weeks). ____ (Initial)

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within **90 days** of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check. Should your insurance carrier require repayment from that refund you are responsible to pay them.

Also remember dental insurance plans are not designed to cover all of your dental needs.

I, _____, have chosen to allow Hill Country Periodontics to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within 90 **days** of my date of service then I will become responsible to pay at that time.

Print Name: **Date:**

_____ _____

Patient Signature: _____

Staff Signature: _____

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do NOT Release Information" box below.

I give the following named person(s) authorization to take messages or speak with the office of Hill Country Periodontics, on my behalf regarding (please check all items authorized).

☐ All ☐ Appointments ☐ Financial ☐ Treatment ☐ Insurance

Name of authorized person(s): _____

☐ All ☐ Appointments ☐ Financial ☐ Treatment ☐ Insurance

Name of authorized person(s): _____

☐ All ☐ Appointments ☐ Financial ☐ Treatment ☐ Insurance

Name of authorized person(s): _____

☐ All ☐ Appointments ☐ Financial ☐ Treatment ☐ Insurance

Name of authorized person(s): _____

☐ All ☐ Appointments ☐ Financial ☐ Treatment ☐ Insurance

Name of authorized person(s): _____

☐DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

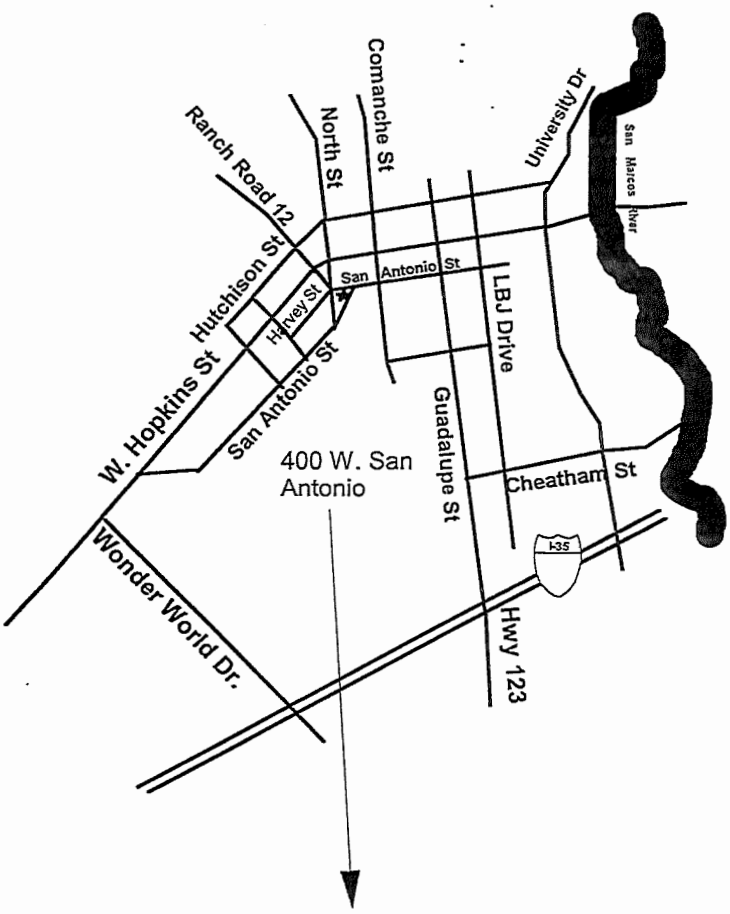
Patient's Name: _____ Date of Birth: _____

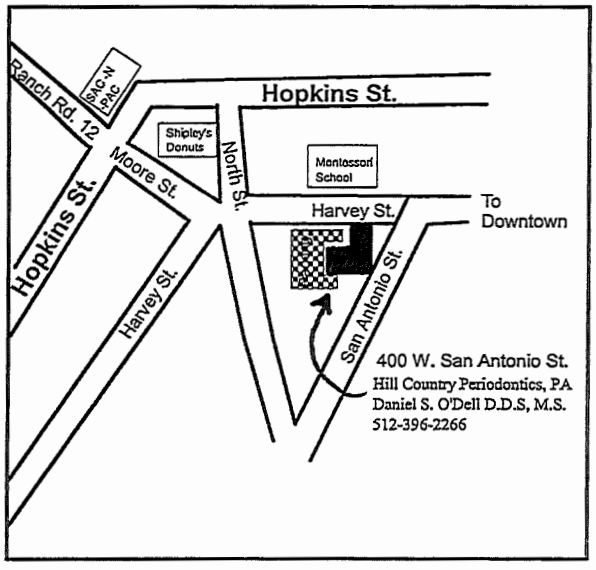
Signature of Patient or Authorized Representative:

_____

Date Signed: _____

Map to San Marcos Office





NOTICE OF PRIVACY PRACTICES

For the office of

Hill Country Periodontics

Daniel S. O'Dell, D.D.S., M.S.

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 (01/23/03), 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 $0.25 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: Dr. Daniel O'Dell

Phone Number: (512)-396-2266