

# HIPAA

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NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

## Dr Jeffrey Fester DMD PC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact

## Dr Jeffrey T. Fester DMD PC

Or our office at

1455 Old Alabama Rd  
Roswell, GA 30076-2129

(770) 587-4202

<http://www.drfeester.com>

### WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

### YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

#### For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

#### For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

#### For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

#### Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

#### Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

#### Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

### SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

#### To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

#### Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

#### Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

#### Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

### **Military, Veterans, National Security and Intelligence**

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

### **Workers' Compensation**

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

### **Public Health Risks**

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

### **Health Oversight Activities**

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

### **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

### **Law Enforcement**

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

### **Coroners, Medical Examiners and Funeral Directors**

We may release health information to a coroner or medical examiner.

This may be necessary, for example, to identify a deceased person or determine the cause of death.

### **Information Not Personally Identifiable**

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

### **Family and Friends**

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

## **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered

by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

## **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding health information we maintain about you:

### **Right to Inspect and Copy**

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

1455 Old Alabama Road, Roswell, GA 30076

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

### **Right to Amend**

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

### **Right to an Accounting of Disclosures**

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

4755 Old Alabama Rd, Roswell, GA 30076

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

### **Right to Request Restrictions**

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the

health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

**We are Not Required to Agree to Your Request**

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

**Dr Jeffrey Fester DMD PC**

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to:

**Dr Jeffrey T. Fester DMD PC**

**Right to Request Confidential Communications**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

**Dr Jeffrey Fester DMD PC**

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

**Dr Jeffrey Fester  
1455 Old Alabama Rd**

**(770) 587-4202  
<http://www.drfeester.com>**

You will not be penalized for filing a complaint.

Signature \_\_\_\_\_

# GENERAL PATIENT INFORMATION

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## Patient Registration

### Patient Information

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status:                      Single                      Married                      Separated                      Divorced                      Widowed

Sex:                      Male                      Female

Social Security Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

### Drivers License

State: \_\_\_\_\_

Number: \_\_\_\_\_

### Home Address:

Address: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

### Billing Address:

Address: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

### Work Information

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Method of Contact:                      Phone                      Email                      Text Message                      Any of the previous ones

### Emergency Contact:

Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relation: \_\_\_\_\_

### How did you hear about our office?

Who may we thank for referring you? \_\_\_\_\_



# PATIENT MEDICAL HISTORY

## Patient's Medical History

### Physician Information

Physician's Full Name: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

Are you currently under a physician's Care?      Yes      No

If Yes, for what?

Have you been hospitalized in the last two years?      Yes      No

If Yes, for what?

Are you taking any medication, drugs or pills?      Yes      No

If so, please list the names and dosages of each:

Do you Smoke?      Yes      No      How Much?      \_\_\_\_\_

### Women Only

Are you pregnant?      Yes      No      Are you taking birth control pills?      Yes      No

Are you nursing?      Yes      No      Are you on Hormone Therapy?      Yes      No

## Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

### Medical Alerts

Allergic to Penicillin	Allergic to Codeine	Pre-Medication required	Pacemaker
Allergic to Tetracycline	Allergic to 'Novocaine'	Mitral Valve Prolapse	HIV Positive
Allergic to Aspirin	Allergic to Latex Rubber	Heart Problems	Prior Hepatitis

Other

### Medical Conditions

Heart Attack	Excessive Bleeding when Cut	Chemotherapy	Osteoporosis
Heart Murmur	Sickle Cell Disease	Ulcers	Swelling of Feet/Ankles
Chest Pain	Glaucoma	Gastrointestinal Upset	Artificial Joint Replacement
Congenital Heart Problem	Diabetes	Acid Reflux	Psychiatric Care
Artificial Heart Valve	Excessive Thirst	Lung Disease	Epilepsy or Seizures
Heart Surgery	Scarlet Fever	Tuberculosis	Extreme Nervousness
High/Low Blood Pressure	Thyroid Disease	Shortness of Breath	Fainting or Dizziness
Rheumatic Fever	Parathyroid Disease	Emphysema	Hypoglycemia
Anemia	Kidney Disease	Asthma	Hives
Blood Disease	Liver Disease	Sinus Trouble	Cold Sores/Fever Blisters
Blood Transfusion	Hepatitis A or B	Hay Fever	Venereal Disease
Stroke	Yellow Jaundice	Frequent Cough	Herpes
Deep Vein Clot	Cancer	Rheumatism	Cortisone Treatment
Hemophilia	X-Ray or Cobalt Treatment	Arthritis/Gout	Chemical Dependency

# PATIENT DENTAL HISTORY

## Patient's Dental History

What is your primary reason for seeking dental care?

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### Previous Dentist Information

Dentist's Full Name: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

Month and Year of Last Visit: \_\_\_\_\_

What was done at your last visit? \_\_\_\_\_

Date of Last full mouth x-rays: \_\_\_\_\_

Reason for leaving previous dentist: \_\_\_\_\_

How often do you visit the dentist?      Annual Check Up                      Twice a Year Check Up  
   Only when I have a problem                      Other

### Please choose the appropriate answer

Are you nervous about receiving dental treatment?	Yes	No	Are you missing teeth that have not been replaced?	Yes	No
Do you gag easily?	Yes	No	Have you had excessive bleeding after an extraction?	Yes	No
Have you had previous problems with dental care?	Yes	No	Have you had mouth sores that take long to heal?	Yes	No
If so, please explain?			Do you have any dental implants?	Yes	No

Are your teeth sensitive to hot, cold, pressure or sweets?	Yes	No	Do you wear dentures (partials or full)?	Yes	No
Do you have problems with teeth/fillings breaking?	Yes	No	Do you have any crowns (caps) or bridges?	Yes	No
Are you aware of an uncomfortable bite?	Yes	No	Do you chew tobacco?	Yes	No
Do your gums feel tender and/or bleed?	Yes	No	Do you have a dry mouth?	Yes	No
Does food catch between your teeth?	Yes	No	Are you unhappy with the appearance of your teeth?	Yes	No
Have you had periodontal (gum) treatments?	Yes	No	Would you like your smile to look better?	Yes	No
Do you get sores in or around your mouth?	Yes	No	Would you like whiter teeth?	Yes	No
Do you have regular headaches, earaches or neck pains?	Yes	No	Do you regularly use dental floss?	Yes	No
Do you grind or clench your teeth?	Yes	No	Do you brush at least once daily?	Yes	No
Do you hear a "clicking" sound when you open/close your mouth?	Yes	No			
Does your jaw ever get "stuck"?	Yes	No			
Do you have a Temporomandibular (TMJ) jaw disorder?	Yes	No			

Is there anything else that you would like us to know?

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site. Yes    No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: \_\_\_\_\_

Dr Jeffrey T. Fester DMD PC  
1455 Old Alabama Rd – Suite 120  
Roswell, GA 30076  
(770) 587-4202

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE**

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*\*You May Refuse to Sign This Acknowledgment\**

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr Jeffrey T. Fester DMD PC  
1455 Old Alabama Rd – Suite 120  
Roswell, GA 30076  
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## Facts You Should Know About Your Dental Insurance

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Dental insurance has played a role in helping people obtain better Dental Care. Since we strongly feel that our patients deserve the best possible treatment we can provide, and in an effort to maintain the highest quality of care, we would like to share the following facts regarding dental insurance in general.

1. Dental Insurance companies do not intend for their plans to cover all expenses occurred during a Dental appointment. The plans serve as an aid toward acquiring better care.
2. Dental plans claiming coverage of '80% or 100%' tend to mislead patients with regards to what the actual amount of coverage will be during your dental visit. The dental plan coverage percentage is NOT based on the fee schedule for any individual office but rather a fee schedule that generally lags behind what the average industry wide fee would be. Each individual dentist sets their own fees and is not governed by any general fee guide. Your best option is to understand your own benefit package and contact the provider to find out your individual situation.
3. Many dental services are covered a specific maximum number of times in a calendar year. It is your responsibility to be informed of your plans limits
4. Some insurance companies tell their clients that the 'Dental fees being charged are above the usual and customary' when in fact the benefit being paid is too low and not keeping pace with the industry costs. You do not have an average mouth and we do not perform average Dentistry, therefore we do not charge average fees. Your treatment plan will be based on your Dental Health needs, not on the amount of benefit you are eligible to receive.

Please do not hesitate to ask any question about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our service and/or fees. We will fill out and file your insurance as a courtesy to you at no charge. We will do all we can to assure you of maximum benefits, **but bear in mind that the insurance company is responsible to you and you are responsible to us for your account.** We cannot render services on the assumption the the charges will be paid by the insurance company.

If you have any questions regarding your insurance, we ask that you contact your employer or insurance carrier regarding the specifics and details of the plan it is conducting on your behalf.