WELCOME TO OUR OFFICE

We at Beck Dental Center, P.C. take great pleasure in welcoming you as a NEW PATIENT. We will do our utmost to make our association a mutually pleasurable experience. We pride ourselves in providing all of our patient's with the very best dental care possible. As such, following are our normal business policies:

INSURANCE: We accept assignment of benefits for MOST insurance plans. However, estimated co-pays, deductibles and/or out of pocket expenses are due and payable at the time services are rendered. If there are more than two insurance carriers involved the patient is responsible for filing any subsequent claims.

As a courtesy we will gladly file your insurance claim[s] and will do our very best to facilitate payment by your insurance carrier. Generally, we allow 60 days for the insurance carrier to pay a claim. In most cases this is sufficient time for a claim to be paid. However, after 60 days the guarantor is responsible for any outstanding account charges.

It is your responsibility to determine if we are a provider on your particular insurance plan, and knowing your dental benefits, including contract frequencies and limitations on services performed.

FINANCIAL ARRANGEMENTS: We have several payment options available to our patients. They allow patients to receive their desired dental care and still remain within their budget:

We accept **ALL MAJOR CREDIT CARDS, CASH, PERSONALCHECKS, DEBIT CARDS and CARE CREDIT [*an INTEREST FREE FINANCE PLAN-*subject to individual approval**)**. Also available is an extended payment plan for up to 60 months with a low interest rate. (**Please ask for details or see the included brochure.**)

We apply a 1-1/2% monthly finance charge (APR 18%) for any charges not paid in full after 60 days.

We offer a **5% discount** when **treatment charges** total over **$1000**; and a **10% discount** if treatment is over **$2500**, The total treatment **must be paid in full with cash or Cashier's Check prior to the start of treatment.** We will file the insurance claim and direct the payment to the insured. In the event the insurance payment comes to the office, a speedy refund will be forwarded to the quarantor. **We DO NOT accept assignment of benefits with these discounts.**

WARRANTY: We warranty all services performed as listed in the provided warranty brochure. Please review for details. You signature below acknowledges receipt of a copy of our warranty brochure.

BUSINESS HOURS:					
MONDAY	**9:00 am to 7:00 pm**	**TUESDAY**	**9:00 am to 7:00 pm**
WEDNESDAY	**9:00 am to 5:00 pm**	**THURSDAY**	**9:00 am to 4:00 pm**
FRIDAY	**CLOSED**	**SATURDAY**	**CLOSED**

WE ARE CLOSED ON MAJOR HOLIDAYS

CANCELLATIONS: We ask that should it become necessary to reschedule or cancel an appointment, please notify our office at least **48 hours prior** in order to allow us the opportunity to offer the reserved appointment time to another patient. We understand that emergencies occur, however, short notice cancellations and NO SHOWS affect all of our patients resulting in time lost and treatment delayed.

When a short notice cancellation or NO SHOW occurs there will be an administrative fee charged for each appointment scheduled in the amount of **$50** for a **weekday** appointment and **$100** for a **Saturday** appointment. **Saturday appointments are premium time and as such so is the administrative fee! When multiple appointments are scheduled on the same day, there is a charge for each appointment scheduled that is missed or cancelled. LATE ARRIVALS** that prevent sufficient time to complete the scheduled procedure(s) will be rescheduled and may be subject to a charge.

We value our patient's time and do everything possible to see each patient at their appointed time. However, please be aware there may be times when emergencies prevent us from seeing a patient at their exact scheduled appointment time. We will give you the option of staying for treatment or offer to reschedule to a more convenient time.

*** THERE IS 24 HOUR VOICE-MAIL AVAILABLE AT ALL TIMES – PLEASE LEAVE A MESSAGE WE WILL RETURN YOUR CALL ***

We at Beck Dental Center, P.C. wish to thank you for the opportunity to provide your dental care and look forward to a long and mutually pleasant association.

Our knowledgeable staff is always available to answer any questions you may have, **please do not hesitate to ask**.

Thank you,
Richard L. Beck, D.D.S.

I have read & acknowledge receipt of a copy of this document and the warranty brochure.

Signature of Patient, Responsible Party or Guarantor _____ Date _____

Beck Dental Center, P.C. 233 E. 84th Drive, Suite 106 Merrillville, Indiana 46410
e-mail address: beckdentalcenter@gmail.com
Phone: 219-736-2309 Fax: 219-736-2328

PATIENT REGISTRATION

Please Print

Date: _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Social Security No: _____ Drivers Lic: _____

Sex: _____Male _____ Female Marital Status: _____Married _____Single _____Divorced _____Separated _____ Widowed

Employer: _____ Student Status: _____Full Time _____Part Time

Employment Status: _____ Full Time _____ Part Time _____ Retired Name of School: _____

Responsible Party (if other than Patient): Relationship to Patient: _____ Self _____ Spouse _____ Child _____ Guardian

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Soc. Sec. #: _____ Drivers Lic: _____

Sex: _____ Male _____ Female Marital Status: _____ Married _____ Single _____ Divorced _____ Separated _____ Widowed

Employment Status: _____ Full Time _____ Part Time _____ Retired Student Status: _____ Full Time _____ Part Time
Name of School: _____

Insurance Information: **Primary Carrier:** Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Guardian

Insured Name: _____ Birth Date: _____

Insured ID # or Soc. Sec. #_____ Group No: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City _____ City: _____

State/Zip: _____ Phone: _____ State/Zip: _____ Phone: _____

Secondary Carrier (if applicable): Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Guardian

Insured Name: _____ Birth Date: _____

Insured ID # or Soc. Sec. #: _____ Group No: _____

Employer: _____ Insurance Co: _____

Address: _____ Address: _____

City: _____ City: _____

State/Zip: _____ Phone: _____ State/Zip: _____ Phone: _____

In Case of Emergency Please Contact:

Name: _____ Phone: _____ Relationship to Patient: _____

Preferences: **Preferred Name:** _____

Preferred Pharmacy: _____ Phone: _____

Address: _____ City, State, Zip: _____

E-mail: _____ I would like to receive notification via e-mail: ____Yes ____ No

BECK
Dental Center

TO ALL OF OUR PATIENTS WITH INSURANCE:

Occasionally, there is some confusion about how insurance carriers process and pay dental claims. We would like to clarify some of this confusion:

We deal with many insurance companies and have several thousand patients. We accept most insurance companies and are a participating provider [PPO] on many. **We will verify coverage and benefits prior to your initial visit only to our office and/or if your carrier changes.**

We do not check your benefits or coverage prior to every visit to the office! This is up to you.

Changes occur to your insurance coverage all the time. Insurance companies do not notify us of these changes. We can only rely on our patients to inform us if there are any changes in the coverage or the insurance company.

As a courtesy we complete your claim for payment and expect you as the recipient of services to pay any co-pays and/or deductibles at the time service[s] are performed. **The amount due is an estimate only**! It is based upon information received from your insurance carrier when we initially verify your benefits. **We are unable to guarantee the amount(s) quoted at the time of service to be exact**! Your insurance carrier determines this based on the contract agreement chosen by your employer.

All charges incurred are billed to your insurance carrier at our normal or standard fee whether or not they are a covered benefit on your policy. Submitting non-covered services establishes a history of use; over time this may encourage insurance carriers to cover these services.

For PPO Plans: A contractual adjustment is made to our standard fee based on your PPO. Occasionally, there may be times this adjustment is different from what we have on file due how your insurance carrier processes your claim. These adjustments and/or corrections will appear on your statement. You as the insured are responsible for any amounts not paid by the insurance plan up to the contracted PPO fee.

For All Insurance Plans: When a service is not covered or denied by your insurance carrier, you, as the insured are responsible for the remaining account balance, knowing what your insurance coverage is, along with its frequencies or limitations on services performed.

Please contact your insurance carrier or employer and request a plan coverage book to review your benefits. Most carriers have a web site with basic benefits listed. **Please be a knowledgeable consumer!**

We try our very best to be as accurate as possible. We will make every effort to correct and/or rectify any and all inaccuracies to the satisfaction of both parties. Please review all statements and call the office immediately if you have any questions or concerns.

I have read and acknowledge receipt of a copy of this document.

_____ Date: _____

Guarantor or Insured signature

Thank you
Beck Dental Center PC
Richard L. Beck, D.D.S.

TO OUR PATIENTS WITH INSURANCE:

Please be advised, we will gladly submit your dental claims for payment and request that you pay your estimated portion at the time services are rendered.

ALSO, PLEASE BE AWARE:

YOU ARE RESPONSIBLE FOR KNOWING WHAT YOUR INSURANCE BENEFITS ARE AND ADVISING THE OFFICE OF ANY CHANGES IN YOUR COVERAGE.

The office will NOT be responsible for denied or non-covered services performed.

Thank You,

Beck Dental Center, P.C.

DENTAL TREATMENT CONSENT FORM

I, the undersigned, understand that I may have or am having any or a combination of the following services: examination; radiographs (x-rays); professional dental prophylaxis (routine preventative cleaning); periodontal treatment (gum disease treatment); endodontic treatment (root canal); fillings; crown restorations; prosthodontics (bridges, dentures or partials); injectible anesthesia; and/or analgesia (nitrous oxide or laughing gas).

I, do hereby authorize Beck Dental Center, P.C., to provide indicated treatment as deemed necessary to provide full and adequate treatment for which I will be given or have been given a full explanation prior to start of treatment. I further understand that I have a full expectation to receive the accepted standard of care for the condition for which I present.

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and or anaphylactic shock (severe allergic reaction).

I fully understand that during the treatment process it may become necessary to change or add procedures because of conditions found while treating the tooth or teeth that were not discovered during examination process. The most common being root canal therapy following routine restorative procedure(s). I give my permission to the treating doctor or designated staff member to make any or all changes and additions as deemed necessary to complete said treatment. I acknowledge that any changes made may affect the final cost of said treatment and I will be given the opportunity to discuss said changes prior to start of procedure.

I understand that it is sometimes not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crown(s) are delivered. I understand and agree that the final opportunity to make any changes in my new crown(s) (cap), or bridge; including shape, fit, size and color will be prior to final cementation (delivery). I further understand that any charges related to my requested changes made after the final delivery will be my responsibility.

I realize that full or partial dentures are artificial and constructed of plastic and/or metal. The problems associated with the wearing of these appliances include, but are not limited to the following: looseness, soreness and possible breakage. I understand and agree that the final opportunity to make any changes in my new appliance; including shape, fit, size, placement and color will be at the final try-in (wax try-in "teeth set in wax") visit. I understand that most immediate placement dentures and/or partials will require a final reline approximately three to twelve months after the initial placement of the appliance. The cost for this procedure is not included in the initial denture/partial charge. I acknowledge that any charges incurred as a result of any changes requested by me after the final completion of the appliance will be my responsibility.

I understand there is no guarantee that root canal therapy will save a tooth, that occasional complications may occur from the treatment, and that occasionally metal objects are cemented in the tooth and/or extend through the root. This does not necessarily affect the success of the treatment. I further understand that occasionally additional surgical procedures may become necessary following root canal treatment, i.e., apicoectomy. I further understand that should a root canal become necessary on a tooth already crowned (capped) there is the possibility the existing crown may fracture resulting in the need for the crown to be replaced. I acknowledge that should this occur I am responsible for the cost of the replacement should my insurance carrier, where applicable, deny coverage for the replacement.

I understand there are alternatives to the extraction (removal) of teeth, i.e., root canal, periodontal surgery, implants, crowns, etc. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

I understand that periodontal (gum) disease is a serious condition causing gum and bone infections, bone loss and can lead to loss of teeth if left untreated. I understand my refusal of treatment will have an adverse affect on my periodontal condition. Alternative treatments, such a gum surgery and or extractions have been offered and explained.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment I have requested and authorized for myself or my minor child or children, where applicable.

I have had or have been given full opportunity to discuss and ask questions regarding any recommended and/or proposed dental treatment; and that any and all my questions have been answered fully to my satisfaction prior to the start of any and all said dental treatment. I further understand that I have the right of refusal of any and all recommended and or proposed dental treatment.

Printed Patient Name _____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative _____ Relationship to Patient _____

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last / First / Middle) Home Phone: Include area code ( ) Business/Cell Phone: Include area code ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: Include area code ( ) Cell Phone: Include area code ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the the question)

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: Include area code ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? Circle one: VERY / SOMEWHA T / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			

WOMEN ONLY Are you:

	Yes	No	DK
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all yes responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: Include area code
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments:

BECK DENTAL CENTER, P.C.

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 ____/____/____, 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._____ for each page, $_____ per hour for staff time to 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: _____

Telephone: _____Fax: _____

E-mail:_____

Address: _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

AUTHORIZATION, RELEASE AND AGRREMENT TO PAY FOR SERVICES RENDERED

I authorize Beck Dental Center, P.C. to release any and all information, including the diagnosis and records of treatment and/or examination rendered to me during the period of such dental care to any third party payor's and/or other health practitioners necessary for obtaining payment of services performed and/or treatment rendered and regardless of DENIAL or DISALLOWED.

I authorize and hereby request my insurance company to pay directly to Beck Dental Center, P.C. any insurance benefits otherwise payable to me. I understand that I am responsible for knowing what my dental benefits, coverage's, limitations and exclusions are, as well as determining whether Beck Dental Center, P.C. is affiliated with my insurance plan. I understand that my dental insurance carrier my pay less than the actual bill for services rendered as a result of these individual contact limitations and/or exclusions. I agree to be responsible for payment of all services rendered on my behalf and/or on behalf of my dependents.

If I do not pay the entire new balance owed within 30 days of the monthly billing date, a late charge of 1.5% per month on the balance then unpaid and owed will be assessed, as allowed by state law.

I realize that failure to keep my account current may result in my being unable to receive further dental services except for dental emergencies or where prepayment for additional services is made.

In the case of default on payment of the account, I agree to pay any and all collection costs, billing fees, accrued interest charges, court costs and reasonable attorney fees incurred in the attempt to collect any outstanding account balances.

I authorize the conversion of any paper checks presented whether in person or by mail to ELECTONIC FUNDS TRANSFER (EFT) and the debiting of my account for payment on my account. If the EFT or check returns unpaid, I agree to pay the EFT or check plus any and all applicable fees or the maximum fee allowed by state law by EFT(s) or check debit (s) to my account.

*I understand a minimum of **48 hours notice** is necessary for cancellation or rescheduling of any appointment or an administrative fee of **$50 for a weekday** appointment will be applied to my account for each appointment scheduled. I further understand **LATE ARRIVAL** to a scheduled appointment that prevents sufficient time to complete the procedure[s] scheduled will be considered a **NO SHOW** and the previously stated fees will be assessed to my account. I understand I will be responsible for the payment of said fee.*

I further understand that any and all estimated co-pays and/or deductibles are due and payable at the time services are rendered.

(For your convenience we offer the following methods of payment: CASH, PERSONAL CHECK, DEBIT CARD, ALL MAJOR CREDIT CARDS AND CARE CREDIT. Please as for details on CARE CREDIT)

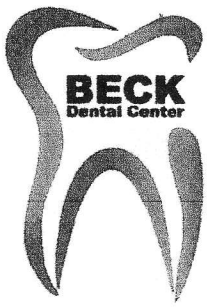
Print Patient Name: _____ *Date:* _____

X _____

Signature Patient, Guardian or Responsible Party

Thank you for your co-operation. Your compliance with the above agreement allows us to more effectively and efficiently meet your dental needs. If you have any questions regarding this agreement, your treatment or your account at any time, please ask. We are always happy to assist you with your questions.

Beck Dental Center, P.C. *233 E. 84th Dr., Ste. 106* *Merrillville, IN 46410* *219.736.2309*



BECK DENTAL CENTER, P.C.
Richard L. Beck, D.D.S.
233 E. 84TH Dr., Suite 106
Merrillville, IN 46410
Phone: 219.736.2309
Fax: 219.736.2328
E-mail: beckdentalcenter@gmail.com

AUTHORIZATION TO RELEASE RECORDS AND/OR RADIOGRAPHS

Accurate diagnosis and treatment planning requires radiographs (x-rays). If you have had any dental radiographs taken at your previous dental office - bitewings (2-4 films) within the last year, panoramic (pano) or full-mouth series (18-22 films) within the last 5 years, we request they be forwarded to our office for our records.

Your insurance carrier places a limitation on the frequency that radiographs may be taken to be covered as a benefit on you policy. If they are not covered as a result of this frequency the patient or guarantor are responsible for the cost of a new one/set to be taken in order to provide you with an accurate diagnosis.

Please complete the following to facilitate our efforts on your behalf to obtain these needed diagnostic tools:

Previous Dental Office Name: _____ Phone: _____

Patient Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional family members to include with this request:

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

I, _____, hereby authorize the release of any current dental records and/or radiographs of the above listed patients. I further request this information be forwarded either by e-mail or mail to the office listed above.

Signature: _____ Date: _____
Patient, Parent or Guarantor