Dr. LAMPEE™
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# HIPAA Notice of Privacy Practices

**This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please read and review carefully.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you that relates to your past, present or future physical, dental or mental health condition and related health care services.

## Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist/physician's practice and any other use required by law.

### Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We will also disclose to a family member, spouse, adult children, any information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons that is necessary to help with your healthcare and/or with payment for your healthcare.

One example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example, we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

### Payment

Your protected health information will be used as needed to obtain payment for your health/dental care services.

For example, obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

### Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of the dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to dental/hygiene students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

## Your Rights

The following is a statement of your rights with respect to your protected health information.

### You have the right to inspect and copy your protected health information

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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**You have the right to request a restriction of your protected health information**

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communication from us by an alternative means or at an alternative location**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively such as electronically.

**You may have the right to have your physician/dentist amend your protected health information**

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number: 815-444-0000.

Patient Name | Patient Signature | Date

**For Office Use Only**

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
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify):

Phone | 503-646-2273
Fax | 503-277-1535
www.drlampee.com
14455 S.W. Allen Boulevard, Suite 103
Beaverton, Oregon 97005

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# Policy Acknowledgment

We are committed to providing you with the best possible dental care. In order to achieve this we need your assistance and your understanding of our payment policies.

## Payment Options

- We accept the following major credit/debit cards: Visa, Mastercard, Discover, and American Express.
- For those who desire a payment plan, we are partnered with Care Credit, Lending Club, and United Medical Credit. These payment plans are based on your approved credit. There are no application fees. These arrangements must be made prior to treatment.
- Payment for treatment is due at time of service. If you are requiring sedation, payment is due upon scheduling the appointment.

## Insurance

- We do not contract or bill insurance. We can provide you with a claim form if you would like to self-bill your insurance.
- Balances over 90 days will be assigned to a collection agency and will incur a $50.00 collection fee. Any checks returned to our office for non-sufficient funds will be subject to a fee of $25.00.
- I have read the Policy Acknowledgment and understand that as a patient, or responsible party, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of this office as stated above.

## Usual and Customary Rates

We charge what is usual and customary for our area. Please be aware that some of the services we provide may not be covered services by your dental plan. You are responsible for payment regardless of your insurance company's exclusions and fee schedules. Your insurance policy is a contract between you and that insurance company. We are not able to negotiate with your insurance company on your behalf.

## Minor Patients

If a minor is not accompanied by their parent/guardian, arrangements for payment need to be made prior to the appointment.

I have read the Policy Acknowledgment and understand that as a patient or legal guardian of a minor patient, I agree to pay all services rendered in accordance with the terms and conditions set forth in the financial policy of this office as stated above.

_____

Patient Signature or Responsible Party Date

The above information is true to the best of my knowledge. I understand that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1.5% will be applied, per month, to accounts over 30 days or more. I authorize Sleep Dentistry Defined to submit charges to cover balances over 30 days or more.

## Credit Card on File

VISA / MC / DIS / AMEX / CareCredit # _____-_____-_____-_____ Exp_____/_____

_____

Patient Signature or Responsible Party Date

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# Missed Appointment Policy

We require two business days' notice to reschedule an appointment. Our business days are Monday–Thursday.

- There is no fee for your first missed appointment. We understand that life happens.
- There is a $50 fee for your second missed appointment.
- There is a $100 fee for your third missed appointment.
- Additional missed appointments will result in us not being to see you as a patient.
- If a sedation appointment or appointment lasting two or more hours is missed or rescheduled with less than two business days' notice, 10% of your appointment cost is non-refundable

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Patient Signature or Responsible Party  Date

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# Patient Information

Name_____Preferred Name_____

Parent/Guardian (if minor child)_____

Address_____Unit_____

City_____State_____ZIP_____

Home Phone_____Work Phone_____Cell Phone_____

Email_____Date of Birth (mm/dd/yy)_____

Who may we thank for referring you?_____

Why are you here today?_____

**Emergency Contact**

Name_____

Home Phone_____Work Phone_____Cell Phone_____

Relationship to Patient: Parent / Guardian / Spouse / Other:_____

☐ Y ☐ N Are you satisfied with the appearance of your teeth?

☐ Y ☐ N Are you interested in Sleep Dentistry?

☐ Y ☐ N Would you like a whiter smile?

☐ Y ☐ N Would you like straighter teeth?

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# Patient Medical History

Name_____ Date_____

Physician's Name_____ Date_____

☐ Check if you are under medical treatment now.

If checked, what for?_____

☐ Check if you are or have ever been hospitalized for any surgical procedure or serious illness.

☐ Check if you are taking any medication(s) including non-prescription.

If checked, what medication(s) or supplements) are you taking?_____

☐ Check if you use tobacco.

☐ Check if you use alcohol.

☐ Check if you use recreational drugs. If checked, which types?_____

**Are you allergic to or have you had any reaction to the following? Check all that apply.**

☐ Topical Anesthetics
☐ Local Anesthetics
☐ Latex
☐ Aspirin
☐ Tylenol
☐ Ibuprofen (Advil)
☐ Prescription Pain Medications
☐ Sulfa Drugs
☐ Penicillin
☐ Sedatives

Other:_____

**Do you or have you had any of the following? Check all that apply.**

☐ AIDS/HIV
☐ Anemia
☐ Angina
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorder_____
☐ Blood Pressure - High
☐ Blood Pressure - Low
☐ Blood Thinners
☐ Cancer
Area_____
Year_____
☐ Chest Pains
☐ Cold Sores
☐ Convulsions
☐ COPD
☐ Diabetes Type I or II
☐ Edema
☐ Emphysema
☐ Epilepsy
☐ Fainting
☐ Frequently Tired
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis Type A / B / C
☐ Joint Replacement
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Mental Illness_____
☐ Osteoporosis
☐ Pacemaker
☐ Radiation
Area_____
Year_____
☐ Restless Leg Syndrome
☐ Rheumatic Fever
☐ Stroke
☐ Thyroid Disorder
☐ Tuberculosis
☐ Ulcers
☐ Weight Loss

Other:_____

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**Women Only. Check if you are:**

- ☐ Pregnant
- ☐ Nursing
- ☐ Taking birth control pills

**Patient Consent Agreement**

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information may be dangerous to my health. I hereby authorize and request the performance of dental services for myself and/or for:

Name_____

I authorize and give consent to perform dental services agreed upon between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated.

Patient or Guardian Signature_____ Date_____

Reviewed and updated_____ Date_____

Reviewed and updated_____ Date_____

Reviewed and updated_____ Date_____

Reviewed and updated_____ Date_____

Reviewed and updated_____ Date_____

Reviewed and updated_____ Date_____

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