

George S. Gayle IV, DDS

1776 Yorktown, Ste 880, Houston, Texas 77056

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 (04/14/03), 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 no more than \$25.00 for the first 20 pages and \$0.15 per page for every copy thereafter. Fees for copying X-rays will be according to the Texas State Board regulations, depending upon the type of x-rays to be duplicated. An additional fee for postage will be charged if you want the copies mailed. 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: **George S. Gayle IV, DDS**

Telephone: **713-627-1090**

Fax: **713-627-9418**

Address: **1776 Yorktown, Suite 880, Houston Texas 77056**

George S. Gayle IV, DDS

1776 Yorktown Suite 880, Houston, Texas 77056

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

{Please Print Name}

{Signature}

{Date}

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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NEW PATIENT INFORMATION FORM

LAST NAME: _____ TITLE: _____ FIRST NAME: _____

MIDDLE NAME: _____ NICK NAME: _____

HOME ADDRESS: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ SS#: _____ - _____ - _____

DOB: ____ / ____ / ____ MARITAL STATUS: _____ SEX: _____

EMAIL ADDRESS: _____ CELL: _____

REFERRING DR: _____ REFERRING PT: _____

MEDICAL ALERTS: _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: _____ - _____ - _____ DOB: ____ / ____ / ____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV YRLY DEDUCT: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: _____ - _____ - _____ DOB: ____ / ____ / ____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV YRLY DEDUCT: _____

RESPONSIBLE PARTY FOR PATIENT:

Name and Address: _____

Signature: X _____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:

Home Phone:	Work Phone:	Birth Date:	Social Security No.:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N

- Are you taking Birth Control Pills?
- Are you pregnant? If Yes, # of weeks
- Are you nursing?

Please answer the following:

Y N

Do you smoke or use tobacco? Height:

For Office Use Only

BP Heart Rate: Weight:

- | Y | N | Conditions |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer- Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Cosmetic Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |

- | Y | N | Conditions |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+ AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumocystitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |

- | Y | N | Conditions |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice |

- | Y | N | Allergies |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |

Other

CONTINUE ON BACK

Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)

George S. Gayle IV, DDS
FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE POLICY

We are committed to providing you with the best possible dental care. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. To assist us in achieving these goals, we ask that you read and understand our financial policy.

Payment in full is due at the time services are rendered, unless payment arrangements have been approved in advance by our practice manager. We will be happy to help process your claim for your reimbursement or you may assign your benefits to the doctor as partial payment toward the services rendered. This can be done after we have had the opportunity to verify your insurance benefits.

At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance policy. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimated treatment calculation or your carriers pre-estimate. **IF YOUR INSURANCE COMPANY HAS NOT PAID THE FULL BALANCE OF THE CLAIM WITHIN 90 DAYS FROM TREATMENT DATE. YOU WILL BE RESPONSIBLE FOR PAYING THE BALANCE.**

Please remember that your insurance is a contract between you and your insurance company and / or employer. Our dental practice is not a party to the contract. We recommend that any questions regarding the amount of insurance coverage for the specific treatment be discussed directly with your insurance company or your employer.

A finance charge of 1.5% per month may be assessed to accounts with balances outstanding for 90 days from treatment date. This **FINANCE CHARGE** represents an **ANNUAL PERCENTAGE RATE OF 18%**.

If your check is dishonored or returned for any reason you will be **charged a \$35.00 processing fee**. All broken appointments without 24-hour **notice** will be charged a **Broken Appointment fee of a minimum of \$50.00 per hour**.

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. In the event of non-payment, the patient or responsible party agrees to pay all the costs of collection including but not limited to attorney fees, court costs, collection agency fees, etc.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/Parent

Date

Witness

Date