SHAUNA L. GAUTHIER
DMD
ORAL SURGERY OF NEW ENGLAND
& DENTAL IMPLANT CENTER

Patient Registration Form

Patient's Name: _____ Date of Birth: _____ Date:_____

Mailing Address: _____City:_____State:_____Zip Code:_____

Home #: _____ Work #: _____ Cell #: _____

Social Security #: _____ Email: _____

Employer:_____ Employer Phone #:_____

Person Responsible for Payment, Other than Insurance:_____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____ Social Security # of Responsible Party:_____

Dental Insurance

Dental Insurance Name: _____ Effective Date:_____

Identification Number:_____ Group Number:_____

Subscriber Name: _____ Subscriber DOB:_____

Subscriber Mailing Address:_____

Subscriber Gender:_____ Relationship to Patient: _____SS# of Subscriber:_____

Medical Insurance

Medical Insurance Name: _____ Effective Date:_____

Identification Number:_____ Group Number:_____

Subscriber Name: _____ Subscriber DOB:_____

Subscriber Mailing Address:_____

Subscriber Gender:_____ Relationship to Patient: _____SS# of Subscriber:_____

Please list the person we can release personal information and account information to. (Example: Spouse, Son, Daughter, etc.) Name:_____ Phone #:_____

I authorize Shauna L. Gauthier, DMD, PLLC and/or her staff to release medical information to the person listed above.

For Patients with Insurance:

We will gladly check your insurance coverage however, if we are unable to verify your benefits, payment is expected in full. Please note that verifying coverage is not a guarantee of payment and you are responsible for any balance that your insurance company does not pay. Failure to pay your balance will result in your account being sent to our collection agency. At that point you will be responsible for your account balance in addition to our collection agency fee of 29%. I authorize Shauna L. Gauthier, DMD, PLLC and/or her staff to submit claims and/or electronic claims to my insurance company to render payment for services on my behalf.

For Patients without Insurance:

You are responsible for your fee in full at the time services are rendered. Failure to pay your balance will result in your account being sent to our collection agency. You will then be responsible for your account balance in addition to our collection agency fee of 29%.

Signature of Patient or Legal Guardian: _____

Signature of Witness: _____

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Health History Form Date:_____

Name: _____ M: _____ F: ____ Date of Birth: _____ Age: _____

Dentist: _____ Referred By: _____Physician:_____

Medications:_____

_____

Allergies:_____

_____

Have you ever had any of the following?

	Yes	No		Yes	No
Heart Disease (chest pain, heart attack)			Asthma		
Rheumatic Fever			Diabetes		
High Blood Pressure			Anemia		
Heart Murmur			Bleeding Problems		
Lung Disease			Immune Deficiency		
Liver Disease (Hepatitis)			Heart Valve Replacement		
Kidney Disease			Have you ever had General Anesthesia?		
Thyroid Disease			Do you Smoke?		
Epilepsy			Are you taking Blood Thinners?		
Stroke			Total Joint Replacement (ex. Hip or Knee)		
Cancer Treatments			TMJ Problems		
Is there any past history of Alcohol or Chemical Dependency that may affect the care we provide?			Are you taking or have you ever taken medication such as: Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Bisphosphonates for osteoporosis multiple myeloma or other cancers?		
Are you pregnant? If yes, what month? _____			Do you need Premedication before surgery?		

List any serious illness or operations: _____

_____

Are you now or have you been under the physician's care in the last five years? Yes____ No_____
If yes please explain: _____

_____

Signature of Patient or Legal Guardian: _____

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Important Notice for All Patients

Kindly give 48 hours advance notice if you are unable to keep your scheduled appointment time.

Missed Appointment Policy

It is the policy of this office to require 48 hours advance notice for all appointment cancellations to allow the physician maximum availability for their patients. To ensure availability is managed appropriately, it is necessary for us to have the following policy for missed appointments:

First Missed Appointment

A notification will be sent to the patient of missed appointment, along with a copy of our office policy, and a bill for a missed appointment charge of $75. This charge is not covered by insurance and is the patient's responsibility. The missed appointment fee must be paid prior to future office visits. **New patients who miss a second scheduled appointment will not be permitted to schedule future appointments or be accepted into the practice**

Second Missed Appointment

A notification will be sent to the patient of missed appointment, our office policy, and a bill for a missed appointment charge of $75. This charge is not covered by insurance and is the patient's responsibility. **The patient may also be dismissed from the practice due to excessive missed appointments.**

Appeal Policy

You have the right to appeal the missed appointment fee by contacting our office manager, Andrea at 603-527-1700. Appeal request will be reviewed by patient's physician and office manager. Appeal decision will be sent in writing to the patient.

I have read and understand the Missed Appointment Policy.

***The receptionist will ask for your signature to acknowledge that you have read and understand this policy.**

SHAUNA L. GAUTHIER, D.M.D., PLLC

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 protected health information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect 04/01/2003, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We use and disclose health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, and insurance company, or another third party. This includes sending electronic claims to your insurance. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone

else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may request that we provide copies in a format other than photocopies. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-mounth period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Website or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practice or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if 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 disclose 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: Shauna Gauthier DMD, PLLC
Telephone: (603)527-1700
Fax: (603)527-1785

Address: 96 High Street, Laconia NH 03246