INFORMED CONSENT:

COVID-19

I understand that I am consenting to an elective dental treatment that is not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective dental treatment can lead to a higher chance of complication and death.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this elective dental procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the treatment.

I have been given the choice to have my dental treatment at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Date: _____

Patient signature:_____

Patient date of birth :_____

Name of provider:_____

Treatment:_____

PATIENT INFORMATION

Name _____ Soc. Sec# _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❒ M ❒ F Age _____ Birthday _____ ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Work Phone _____

INSURANCE INFORMATION

Subscriber Name _____ Subscriber ID# _____

Company Name _____ Date of Birth _____ Group # _____

Address for Claims _____ Phone # _____

MEDICAL HISTORY

Physician's Name _____ Phone _____

Date of Last Visit _____ Have you had any serious illnesses or operations ❒ Y ❒ N

If yes, describe _____

Are you currently under physician care? ❒ Y ❒ N If yes, describe _____

Have you ever had a blood transfusion? ❒ Y ❒ N If yes, give approximate dates _____

Women: Are you pregnant? ❒ Y ❒ N Nursing? ❒ Y ❒ N Taking birth control pills? ❒ Y ❒ N

Check (✓) yes or no whether you have had any of the following:

❒ Y ❒ N AIDS/ HIV Positive
❒ Y ❒ N Anaphylaxis
❒ Y ❒ N Anemia
❒ Y ❒ N Arthritis, Rheumatism
❒ Y ❒ N Artificial Heart Valves
❒ Y ❒ N Artificial Joints
❒ Y ❒ N Asthma
❒ Y ❒ N Atopic (allergy prone)
❒ Y ❒ N Back Problems
❒ Y ❒ N Blood Disease
❒ Y ❒ N Cancer
❒ Y ❒ N Chemical Dependency
❒ Y ❒ N Chemotherapy
❒ Y ❒ N Circulatory Problems
❒ Y ❒ N Cortisone Treatments
❒ Y ❒ N Cough, Persistent
❒ Y ❒ N Cough up blood
❒ Y ❒ N Diabetes
❒ Y ❒ N Epilepsy
❒ Y ❒ N Fainting
❒ Y ❒ N Food Allergies
❒ Y ❒ N Glaucoma
❒ Y ❒ N Headaches
❒ Y ❒ N Heart Murmur
❒ Y ❒ N Heart Problems
Describe _____
❒ Y ❒ N Hemophilia/ Abnormal Bleeding
❒ Y ❒ N Hepatitis
❒ Y ❒ N Herpes
❒ Y ❒ N High Blood Pressure
❒ Y ❒ N Jaw Pain
❒ Y ❒ N Kidney disease or Malfunction
❒ Y ❒ N Liver Disease
❒ Y ❒ N Material Allergies (latex, wool, metal, chemicals)
❒ Y ❒ N Mitral Valve Prolapse
❒ Y ❒ N Nervous Problems
❒ Y ❒ N Pacemaker/Heart Surgery
❒ Y ❒ N Psychiatric Care
❒ Y ❒ N Radiation Treatment
❒ Y ❒ N Rapid Weight Gain or Loss
❒ Y ❒ N Respiratory Disease
❒ Y ❒ N Rheumatic/ Scarlet Fever
❒ Y ❒ N Shingles
❒ Y ❒ N Shortness of Breath
❒ Y ❒ N Skin Rash
❒ Y ❒ N Spina Bifide
❒ Y ❒ N Stroke
❒ Y ❒ N Surgical Implant
❒ Y ❒ N Swelling of Feet or Ankles
❒ Y ❒ N Thyroid Disease or Malfunction
❒ Y ❒ N Tobacco Habit
❒ Y ❒ N Tonsillitis
❒ Y ❒ N Tuberculosis
❒ Y ❒ N Ulcer/Colitis
❒ Y ❒ N Venereal Disease

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all: _____

Signature _____ **Date** _____

Payment is due in full at time of treatment unless prior arrangements have been made.

d'andrea pantera
Family & Cosmetic Dentistry

ACKNOWLEDGMENT OF RECEIPT OF

HIPAA PRIVACY PRACTICES AND OFFICE PAYMENT POLICY

Restoring your oral health is our foremost objective. Our treatment will always be rendered solely on the basis of your individual needs and not dictated by insurance. We require payment at the time of services unless special arrangements have been previously made. We accept cash, checks, VISA, MasterCard, Discover, American Express, and Care Credit. Please advise us if you are unable to comply with our policies so that we may discuss and consider alternative payment options for your treatment needs.

REGARDING ALL INSURANCE: We cannot promise that an insurance company will pay for your care, even when it is pre-authorized or estimated. We will submit bills to your insurance carrier as a courtesy but will not become involved in disputes between the insured and the insurance company. This courtesy will commence as soon as we are able to confirm overage for services and have the proper, signed insurance forms.

Payment of non-covered services and co-payments is expected at the time of service.

We strongly urge you to contact the insurance company to verify your benefits, as sometimes incorrect information is provided to us. If an insurance company fails to pay for services within 90 days, the undersigned is responsible for payment. If the insurance company erroneously pays directly to the insured, the amount shall be forwarded to this office within three (3) days. Ultimately, you are responsible for all outstanding balances. After reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary.

ASSIGNMENT OF BENEFITS: I hereby assign all insurance benefits to be payable to D'Andrea & Pantera, DMD,PC. If not, I assume all financial responsibility for my account.

MISSED/CANCELED APPOINTMENTS: Personal attention and care are extremely important to your dental care and your appointment time is reserved especially for you. We respect your time, please respect ours. As a result, there is a **$50** charge for missed hygiene appointments, **$100** for missed Doctor appointments without 24 hour notice. In addition, missed appointments on a Saturday will be **$100**. This missed appointment charge is the patient's responsibility and cannot be billed to the insurance company. Missed appointment fees must be paid before scheduling or at subsequent appointments. If more than three (3) are missed without notification, we will recommend that you seek treatment at another facility that can better accommodate your needs.

RETURNED CHECKS WILL BE SUBJECT TO A $15.00 BANK PROCESSING FEE.

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

(please print name)

_____ _____

(signature) (permission to speak with)

_____

(date)

You may refuse to sign this acknowledgement.

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
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgment
( ) Other (Please specify)

{D'Andrea & Pantera, D.M.D PC}

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 (April 3, 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. 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 $0.05___ for each page, $20.00 per hour for staff time to locate and 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: Jodie Celentano

Telephone: (203) 288-0951 Fax: (203) 281-1167

E-mail: jodie2675@yahoo.com

Address: 2675 Whitney Ave. Hamden, CT 06518

Records Release Request

I hereby authorize and request _____ to release my dental radiographs, dental records and medical records pertinent to my dental treatment, or copies of such, to:

D'Andrea and Pantera D.M.D., PC
2675 Whitney Avenue
Hamden CT, 06518
Phone: 203-288-0951
Fax: 203-281-1167
Email: dpdentistry@yahoo.com
www.dpmgeneraldentistry.com

Please indicate the reason for record request below:

- ☐ This is a permanent dental office change (please note reason for change) _____
- ☐ This is a request for a specialist visit or a second opinion

- ☐ I understand that according to state law, a reasonable fee may be assessed for the copying of my records.

Patient Name(s) (please print): Date:

Patient/Parent Signature: