Scott O. LaFevers, D.D.S., M.B.A.

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 14, 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 DISCLOSURESOF 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 or 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 practice 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 may charge you a minimum fee of $ 10.00 or $.75 per page for the first 25 pages;$.50 per page for pages 26-100; and $.25 per page for each page in excess of 100 pages. If you request an alternative format, we may 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 a 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 an 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 enlit1eclto 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: Administrator or Designee

Telephone: 919.736.4830 Fax: 919.736.7038 E-mail: scott@lafeversdental.com

Address: 101 Stevens Memorial Place Goldsboro, NC 27534

Scott O. LaFevers, D.D.S., P.A.
(LaFevers Dental Team)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I_____, have been offered 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 of acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

Financial Policy for the Insured Patient

Please retain for future reference

- It is the patient's responsibility to present a current insurance card at each visit and to notify our office if you have any changes with your insurance. Otherwise, you may be responsible for payment.
- Our office does verify benefits and authorizations for services making every effort to provide you with accurate information. Please note that we are not responsible for incorrect information provided to us by your insurance company.
- We verify insurance benefits and file claims as a courtesy to our patients. Please know that we do so with your total service in mind.
- The law requires insurance companies to pay claims within 30 days of submission. Our billing department will make every effort to work with you and your insurance company to resolve claim issues. After 60 days, if your insurance company has failed to pay a claim and you as the patient have not provided accurate information or refuse to assist with insurance matters, you will be responsible for payment. If the insurance company pays after we receive payment from you, we will issue an immediate refund.

I hereby acknowledge that I have read, understand and agree to the terms of this document relating to insurance coverage and payment of my services.

Patient Name: _____

Patient or Guardian's Signature _____ **Date**_____

New Patient Information

Patient Name: _____ **DOB:** _____ **Date**: _____
Last First Middle

Phone Numbers: (Cell)_____(Home)_____ **Employer:**_____

Address:_____
Street Apartment#

_____, _____ _____**Name of DENTAL Ins Company?**_____
City State Zip Code

Name of Person Responsible for Payment: _____ Social Security Number: _____- _____- _____

Do you require Pre-Medication (Antibiotics) before dental treatment? **YES or NO**
Do you have any artificial joints? (Knee Replacement, Hip Replacement, etc**) YES or NO**
Are you currently on a blood thinner? **YES or NO** Do you have High Blood Pressure? **YES or NO**
Are you Pregnant? **YES or NO** (If yes, when is your due date?) **__/___/___**

Are you allergic to anything? **YES or NO** If **yes**, what are you allergic to? _____

Have you ever had surgery? **YES or NO** If **yes**, please list what surgery you have had? _____

Please List All Medications you are currently taking. Include the **name, dosage, and reason for taking.**

_____

_____

Who is your primary care physician? _____ What Pharmacy do you use? _____

Have you ever taken- Actonel? **YES or NO** Boniva? **YES or NO** Fosamax? **YES or NO** Reclast? **YES or NO**

Do you currently take- Plavix? **YES or NO** Coumadin**? YES or NO** Warfarin**? YES or NO** Daily Aspirin? **YES or NO**

Have you ever had? Head/neck radiation treatment? **YES or NO** Heart attack in the last 6 months? **YES or NO**

Please Check those that apply:

- o AIDS/HIV/ Venereal Disease
- o Anemia
- o Arthritis
- o Artificial Joints
- o Asthma
- o Blood Disease
- o Cancer
- o Diabetes
- o Dizziness
- o Epilepsy
- o Excessive Bleeding
- o Fainting
- o Growths
- o Hay Fever
- o Head Injuries
- o Heart Murmur
- o Hepatitis
- o High Blood Pressure
- o Jaundice
- o Kidney Disease
- o Liver Disease
- o Nervous Disorders
- o Pacemaker
- o Radiation Treatment
- o Rheumatic Fever
- o Respiratory Problems
- o Rheumatism
- o Reaction to local anesthetics
- o Stomach Problems
- o Stroke
- o Tuberculosis
- o Tumors
- o Ulcers
- o Codeine Allergy
- o Penicillin Allergy
- o Thyroid
- o Latex Allergy
- o Heart Disease

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

_____ _____
Signature Date

LaFevers Dental Team

101 Stevens Memorial Place / Goldsboro NC, 27534 / (919) 736-4830

Thank you for choosing LaFevers Dental Team to treat your dental needs. Our primary vision is to exceed our patients' expectations in every way possible. We will obtain our success by providing the best quality dentistry complemented by the very best customer service on a daily basis in a state of the art facility. By being actively involved in local community outreach, we will continue our growth and foster our reputation. Our patients become our family, our community becomes our practice.

Our Office Policies and Facts

- At LDT, we have a 48 hour cancellation policy. We reserve the right to charge a $25.00 fee for any no shows or cancellations. However, we do understand emergencies, death, illness ,etc. (For families that schedule several appointments on the same day, we kindly ask for a 48 hour notice. If not, we may not be able to schedule the entire family together again.)
- We do NOT offer any "In- House" payment plans. Although, we do accept Care Credit which does allow you to pay over time. Anything over $200.00 in our office allows you to pay 6 or 12 months with NO interest! Other payment options include: Cash, Check, Visa, MasterCard, and Discover. No discounts are given for full payment in cash.
- We offer Nitrous Oxide to patients over the age of 3 to help alleviate any added anxiety that you may have. This is not the same as being sedated. You will be awake the entire appointment and once the procedure is complete you will be able to drive.
- As a courtesy to our patients, we guarantee a three year warranty on all recommended crown and/or bridge as long as you maintain your re-care appointments as recommended by your treating doctor.
- We recommend getting an annual oral cancer screening with Velscope powered by Sapphire. This will be offered to you during your cleaning appointments.
- A few additional services that our office may offer included: Bleaching (Take Home, Custom Trays, In-House), Mini Implants, Invisalign, Traditional Ortho, and some Oral Surgery cases.
- At LDT, we have 3 family General Dentists (Dr. Scott LaFevers, Dr. Spencer Dail, Dr. Arthur Knight), 1 Oral Surgeon (Dr. Frederick Nance), and 2 Orthodontists (Dr. Lee Lewis, Dr. Derek Steele). Upon meeting our doctors, if you should have a preference on who you would like to see, please inform our staff so that we can try our very best to accommodate you and schedule accordingly.

LaFevers Dental Team requires payment on the date treatment is rendered. If you choose to pre-pay and discontinue care before treatment is complete, your refund will be determined upon review of your case.

As a courtesy, for patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However please understand our treatment plans are just an ESTIMATE, and your insurance may cover differently than we anticipate! We work diligently to try and obtain a breakdown of benefits for each patient, but this is never a guarantee of coverage. (Please take into account if we do not receive payment from your insurance carrier within 90 days, you are primarily responsible for payment).

LaFevers Dental Team charges $25.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print) Date