1810 Crooks Ave
Suite C
Kaukauna, WI 54130

Notice of Privacy Practices - Patient Acknowledgement

I have received this practice's Notice of Privacy Practice written in plain language. The notice provides in detail the uses and disclosures of my protected health information, my individual rights, and this practice's legal duties with respect to my protected health information.

- This practice is required by law to maintain the privacy of protected health information.
- This practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment, and health care operations.
- A description of each of the other purpose for which this practice is permitted or required to use or disclose protected health information without my written consent.
- A description to use or disclose protected health information without my written concent.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights:
    - □The right to complain to this practice and to the Secretary of HHS, if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
    - □The right to request restrictions on certain uses and disclosures of my protected health information
    - □The right to receive confidential communications of the protected health information
    - □The right to inspect and copy protected health information
    - □The right to amend protected health information
    - □The right to receive an accounting of disclosures or protected health information
    - □The right to obtain a copy of the Notice of Privacy Practices

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain the practice's current Notice of Practices of request

Signature: _____ Date: _____

Relationship to patient (if signed by personal representative of patient):_____

Krupka Dental Financial Policy

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that ALL PATIENTS PAY FOR THEIR TREATMENT IN FULL ON THE DAY OF EACH VISIT to our office unless prior arrangements have been made

INSURANCE As a courtesy to you, Krupka Dental will handle all claim submissions to primary and secondary insurance carriers. However, you must provide us with **current** copies of your insurance card(s) and notify us **immediately** when there are any changes in this information. If your carrier has not paid your claim within 45 days of submission, you will be responsible for payment. Any questions regarding your coverage, eligibility and benefits (payments) must be communicated by you directly with your insurance company as you hold the contract with that company. ***WE BILL YOUR INSURANCE AS A COURTESY TO YOU.*** Please note: The insured is responsible for payment on any claims that are 1)applied to deductable or co-insurance; 2)denied; 3)partially paid; 4)partially paid due to the carrier's arbitrary determination of usual and customary rates.

COPAYS are due at the time of service which includes your ***estimated*** portion of treatment not covered by your insurance plan.

NO INSURANCE (Self Pay) Effective 10/01/2014 anyone without dental insurance can receive a 10% discount if balance is paid in full at the time of appointment. Otherwise, call the patient coordinator to set up a pre-payment plan

TREATMENT PLANS *We will do our best* to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close *estimate* of your next visits total bill. Please bring cash, check, Visa or MasterCard at the time of treatment. With a proper diagnosis and a timely treatment plan, most *estimates* we provide are accurate

OUTSTANDING BALANCES on your account are discouraged, and must be cleared before the next appointment for any member or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payments of outstanding balances. Monthly accruing interest at the rate of 1% of the balance****DELINQUENT BALANCES OVER 90 DAYS WILL BE REFERRED TO Finance Systems of Green Bay FOR COLLECTIONS****

DIVORCE/SEPARATION AND BILLING We understand that many children live in more than one home because of divorce. We know many issues arise in divorce cases, but our policy is simple. Ultimately, the parent who brings the child in for visits and signs the financial agreement will be considered the responsible party and will receive billing statements.

A RETURNED CHECK FEE of $40(subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check the $40 fee plus full payment for the check that did not clear must be paid in cash, or by VISA or MasterCard

CARE CREDIT Care Credit is a leading patient program that offers you a way to finance your dental needs with interest free programs and payment plans. It offers a convenient way to help you pay for treatments and procedures your insurance doesn't cover- it puts the decision of your care in your hands. It takes only minutes to apply in our office or online.

I have read the Financial Policy and understand its content. I agree to the terms of the policy

X_____

PRINT Patient Name

X_____ _____

Signature of Patient or Responsible Party Date

We are pleased to welcome you to our practice. This medical history form will help us to better treat you as a patient. Please fill out this as completely as possible.

How did you hear about us?: _____

Patient information::

Name (First, middle initial, and last): _____
Email: _____

Home phone: (_____)_____ □ Best phone number
Cell phone: (_____)_____ □ Best phone number
Other phone: (_____)_____ □ Best phone number

Date of birth: _____/_____/_____ Age: _____ □ Male □ Female

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

Social Security number: _____-_____-_____
OR
Drivers license number: _____

□ Married □ Single □ Partnered □Widowed □Minor

I hereby agree and permit Krupka Dental Associates to disclose any medical and/or billing protected healthcare information to the following: (EX: Spouse, parent, child, friend)

Name and relationship: _____
Name and relationship: _____
Name and relationship: _____
Name and relationship: _____

INSURANCE INFOMATION:
Name of insured person: _____
Who is this person employed by: _____
Date of birth of insured person: _____
Social security number of insured person: _____

Medical history::

Physician's name: _____ Physician's phone: _____

Last time you visited your physician: _____

Please check any of the following that apply to you:

□ Anemia
□ Arthritis
□ Artificial Heart Valves
□ Artificial joints
□ Blood thinners
□ Cancer
□ Chemotherapy
□ Diabetes
□ Epilepsy
□ Glaucoma
□ Hepatitis
□ Heart problems
□ High Blood Pressure
□ High Cholesterol
□ HIV/AIDS
□ Jaw Surgery
□ Kidney Disease
□ Liver Disease
□ Pacemaker
□ Radiation Treatment
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Shortness of Breath
□ Sleep apnea
□ Snoring
□ Thyroid Problems
□ Tobacco habit
□ Tonsillitis

For staff use only::

Have you been hospitalized for any surgeries that were not mentioned in this health history? If yes, please list: _____

Is there anything else in your health history you would like us to know? _____

_____

WOMEN::

Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control: □ Yes □ No

Dental history:

Former dentist: _____ Last date of dental care: _____
Do you like your smile? □ Yes □ No
If no, what would you like to change?: _____
Do you have a fear of going to the dentist? □ Yes □ No

Check if you have the following:

□ Bad Breath	□ Bleeding gums	□ Periodontal treatment
□ Lost/Broken fillings	□ Sores/growths in mouth	□ Clenching
□ Sensitivity to hot	□ Grinding teeth	□ Sensitivity to sweets
□ Sensitivity to cold	□ Food collection between teeth	□ Dental pain

How often do you brush?: _____How often to do you floss?: _____

Allergies:

_____
_____
_____
_____
_____

Medications (Currently taking):

_____
_____
_____
_____
_____

Please state any questions or concerns you have:

By signing this form I am stating that all of the information is filled out to the best of my ability:

Signature: _____ Date: _____