TO OUR PATIENTS

This notice describes how health information about you (as a patient at Keystone Dental Care, Inc.) may be used and disclosed, and how you can get access to your health information.

This is required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

This notice takes effect April 14, 2003 and will remain in effect until it is replaced

Keystone Dental Care, Inc.
603 Bert Street Box 12
Suite 206
Johnson City, Tennessee 37601
(423) 232-7919

Keystone Dental Care, Inc. is funded in part by
State of Tennessee
ARC
City of Johnson City
Mountain States Health Alliance
Iris Glen
Noon Rotary of Johnson City

Keystone Dental Care, Inc.
Is a
United Way Agency

KEYSTONE
DENTAL CARE,
INC.
OUR COMMITMENT TO YOUR PRIVACY

Keystone Dental Care, Inc., its staff and volunteers are dedicated to maintaining the confidentiality of your health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. New Privacy Practices will be posted and made available upon request.

We realize that these laws are complicated, but we must provide you with the following information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health over-site agencies that are authorized by law to collect information.

2. To volunteer dental care providers in order to prevent a threat to your health in the administration of medications and treatment.

3. In connection with our health care operations, including training programs, case studies, certification, licensing and credentialing activities.

4. If required to do so by a law enforcement official.

5. When it is necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make information available to persons or organizations able to help prevent the threat.

6. You may give us written permission to disclose your health information to a family member, friend or other person, when it is necessary to help with your healthcare.

7. Our clinic will not use your information for case studies or marketing communications without your written consent.

8. Our clinic may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes.

9. To proper authorities in situations of national security.

10. To provide appointment reminders.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You have the right to ask that our clinic communicate with you about your health and related issues in a particular manner or at a certain location. You must submit these requests in writing.

2. You can request a restriction in our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we are bound by these restrictions, EXCEPT IN THE CASE OF EMERGENCY.

3. You have the right to obtain a copy of, or look at your health information, with the exception of clinic notations, which will be provided only to another health care provider. You must provide a written request for treatment notes to be transferred to another health care provider.

4. You may request to change your health information if you believe that it is incorrect or incomplete.

5. You have the right to request a copy of this notice at any time.

6. You have the right to request a list of instances in which your health information has been disclosed.

7. You have the right to file a complaint. If you believe that your privacy rights have been violated. You may file a complaint with this clinic or U.S. Department of Health and Human Services. This complaint must be submitted in writing.
I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices.

Patient Name: ____________________________________________________________
(Please Print Name)

Signature: _____________________________ Date: ___________

I give my consent for the following people to receive my personal health information.

1. __________________________________________________
2. __________________________________________________
3. __________________________________________________

Signature: _____________________________ Date: ___________
Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

### Are you in good health?
- Yes
- No

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has there been any changes in your general health within the past year?</td>
<td></td>
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<tr>
<td>Are you under a physician's care now?</td>
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<tr>
<td>Have you ever been hospitalized or had a major operation?</td>
<td></td>
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<tr>
<td>Are you taking any medications, pills, or drugs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?</td>
<td>Yes</td>
<td>No</td>
<td>If yes</td>
</tr>
<tr>
<td>Do you take, or have you taken, Phen-Fen or Redux?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Do you use smokeless tobacco or smoke?</td>
<td>Yes</td>
<td>No</td>
<td>If yes</td>
</tr>
<tr>
<td>Do you use aspirin?</td>
<td>Yes</td>
<td>No</td>
<td>If yes</td>
</tr>
<tr>
<td>Do you take blood thinner (Anticoagulants)?</td>
<td>Yes</td>
<td>No</td>
<td>If yes</td>
</tr>
<tr>
<td>Do you take Aspirin?</td>
<td>Yes</td>
<td>No</td>
<td>If yes</td>
</tr>
</tbody>
</table>

#### Women: Are you...
- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

### Are you allergic to any of the following?
- Aspirin
- Penicillin
- Codeine
- Antibiotics
- Latex
- Sulfa Drugs
- Local Anesthetics
- Barbiturates

#### Do you have, or have you had, any of the following?
- AIDS/HIV Positive
- Hepatitis B
- Hepatitis C
- Emphysema
- High Cholesterol
- Excessive Thirst
- Irregular Heartbeat
- Kidney Problems
- Stomach Ulcer/Hyperacidity
- Stroke
- Cancer
- Coronary Insufficiency
- Heart Pacemaker
- Heart Trouble/Disease
- Physically Inactive
- Allergies
- Unborn Heart Defect

### Have you ever had any serious illness not listed above?
- Yes
- No

### Have you used any non-prescription drugs prior to this appointment?
- Yes
- No

### Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**Signature of Patient, Parent or Guardian:**

X

**Date:**

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**Signature of Dentist:**

X

**Date:**
It is the policy of Keystone Dental Care Inc. to provide essential dental services. Fees are determined depending upon family income and size. Please complete the following information to determine if you or members of your family ages 19 years and above are eligible for treatment. In the hope that your economic health improves, discounts apply only for a one year period.

Please list household members

Number of people in Household ___________

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>Dependent</td>
<td>Spouse</td>
<td>Dependent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dependent</td>
<td>Dependent</td>
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<tr>
<td></td>
<td></td>
<td>Dependent</td>
<td>Dependent</td>
</tr>
</tbody>
</table>

**ANNUAL HOUSEHOLD INCOME**

Please list income from any of these sources

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Self</th>
<th>Spouse</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross wages, salaries, tips, etc.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Social security, pension, annuity, and veteran’s benefits</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Alimony, child support, military family allotment</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from self employment, and dependents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Verification Checklist (attach copies)**

Yes | No

Income: Prior year tax return, three most recent pay stubs, verification of alimony, verification of child support, copy of social security income, or other

I certify that the information shown above is correct and understand verification is required before treatment is approved.

Signature ___________________________ Date ___________

**Office Use Only**

Pay class approved: ___________________________ Effective date: ___________________________

Approved by: ___________________________ Expiration date: ___________________________
KEYSTONE DENTAL CARE, INC
Confidential Application for Service

DATE:______________

In accordance with the State of Tennessee’s policy of nondiscrimination, Keystone Dental Care, Inc. does not discriminate on the basis of race, color, religion, national origin, physical or mental disabilities, veteran status, or sexual orientation in it’s policies, dental treatment, services or activities.

Name ______________________________________________ SS# __________________

Address____________________________________________ Phone ________________

City __________________________ State _____ Zip Code _______ County __________

Work Phone OR phone where message can be left: __________________________________________

Date of Birth:___________________________________ Sex: Male Female

Race: White Black Hispanic Other Age: __________________________

Emergency contact person________________________________________ Phone __________________

Are you currently homeless? Yes No

Are you an active Families First participant? Yes No

Do you have:

- TennCare? Yes No
- Medicare? Yes No
- Veteran’s Benefits? Yes No

Do you have insurance that covers a dental visit? Yes No

Do you have a private physician? Yes No
If yes, who? ___________________________ Phone Number ___________________

Do you have a private dentist? Yes No If yes, who? __________________________

Are you a patient at Johnson City Downtown Clinic? Yes No

Are you a patient of the JCMC Senior Partners Clinic? Yes No

To the best of my knowledge, all of the above information is truthful and complete:

Signature _________________________________________ Date_______________________
KEYSTONE DENTAL CARE

PROOF OF INCOME

*** PLEASE NOTE: A SEPARATE “PROOF OF INCOME” MUST ACCOMPANY THIS APPLICATION BEFORE AN APPOINTMENT IS MADE.

*** PLEASE NOTE: “PROOF OF INCOME” RELATES TO HOUSEHOLD INCOME; THEREFORE, WE NEED YOUR INCOME AND THE INCOME OF ANY AND ALL PERSONS, RELATIVE OR FRIEND, LIVING IN YOUR HOUSE WITH YOU WHO EARN AN INCOME AND ANY OTHER OUTSIDE SOURCE OF INCOME (RENT OR UTILITIES PAID BY SOMEONE ELSE NOT LIVING WITH YOU). AS SOON AS THIS APPLICATION IS COMPLETE WE WILL CALL YOU TO MAKE AN APPOINTMENT.

THE FOLLOWING ARE EXAMPLES OF “PROOF OF INCOME”:

1) PRIOR YEAR FEDERAL TAX RETURN
2) 3 MOST RECENT PAY STUBS
3) VERIFICATION OF ALIMONY
4) VERIFICATION OF CHILD SUPPORT
5) COPY OF SOCIAL SECURITY INCOME
6) COPY OF FOOD STAMP LETTER

THANK YOU,

KEYSTONE DENTAL CARE
Due to the extreme need for dental treatment and the number of patients seeking treatment, broken appointments will not be tolerated.

- **It is the responsibility of each patient** to call KDC if they cannot come to a scheduled appointment.

- You must cancel your appointment twenty-four (24) hours before your appointment.

- If your appointment is not canceled in advance it will be considered a broken appointment and you will **you will be charged a $25.00 fee.** You will forfeit further treatment until that fee is paid.

_________________________        ____________
Patient Signature        Date

_________________________
Print Name
Keystone Dental Care copayments must be made in CASH ONLY. The copayments are due the day of service and BEFORE treatment is rendered. Keystone Dental Care does not accept bills larger than $50.00 for payment.

Thank you for your cooperation.

Name:

Date: