simpsonville dental associates

(864) 963-3601
315 West Georgia Rd
Simpsonville, SC 29681
SimpsonvilleDental.com

Welcome

Our mission here at Simpsonville Dental Associates is to provide exceptional dental care, using the latest proven advances in dentistry, in a caring and relaxed atmosphere. We work to earn our patients' confidence everyday through the high quality of our service. We strive for long-lasting relationships with each of our patients, based on honesty, integrity, and sincere appreciation for the trust you place in us. We recognize that each patient is an individual. Our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.

At your first visit, we will take the time to get to know you. The doctor will perform a comprehensive dental exam, review necessary x-rays, and make an assessment of your oral condition. Together we will discuss your dental needs and desires. A customized treatment plan and estimate will be prepared for you before beginning any treatment.

Prior to your appointment, please provide us with your most current dental insurance card to assist us in the benefit verification process. At the time of service, we will expect payment of your portion due. If you do not have a dental benefit plan, special financing through CareCredit® is available. We also accept Visa, MasterCard, American Express and Discover.

Our office hours are from 7:30am until 4:30pm Monday through Thursday and some Fridays. We kindly ask that you make every effort to keep your reserved appointments. As a courtesy to us and other patients, please call us at least 1 business day before your appointment if you need to reschedule it. Ask us about our new electronic appointment system, which can remind you of your appointments as well as allow you to request and confirm appointments via email and/or text messaging.

We are conveniently located off I-385, exit 29. We appreciate the confidence and trust that you have placed in us, and we look forward to meeting you soon!

Sincerely,

The Simpsonville Dental Associates Team

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(864) 963-3601
sda@smiledox.com

315 West Georgia Road
Simpsonville, SC 29681

Appointment Agreement

We greatly appreciate your decision to come to us for your dental needs. Our front office team will contact you at least 1 business day prior to your appointment. For your convenience, we also offer email and text reminders. If you are interested in this convenient option, please let us know.

As our patient, and to ensure we deliver exceptional dental care, we are 100% committed to providing quality service in a timely manner to all of our patients. We believe that an important aspect of delivering exceptional dental care requires mutual respect of patient / doctor time, as the scheduled appointment will be reserved for you. Please plan to come in just a few minutes early to each appointment so that we can update any necessary information such as your medical history, insurance, address, phone numbers, etc.

Missed appointments increase the cost of healthcare for everyone. Our office hours are Monday through Thursday, 7:30am – 4:30pm. In the event that you need to reschedule your reserved appointment, we require a 1 business day notice. Appointments not rescheduled with 1 business day notice will be considered a broken appointment, and if a 2nd appointment is broken within a 12 month period, a reservation fee of $50.00 may be assessed per appointed family member and collected prior to scheduling the next visit(s). The reservation fee will be applied to any future dental treatment, or forfeited if the appointment is broken again. Please contact us at 963-3601 if you have any questions. Thank you for your understanding.

Sincerely,

The Simpsonville Dental Associates Team

I have read, understand, and agree to honor the Appointment Agreement above.

Signature _____

Date _____

NEW PATIENT INFORMATION & MEDICAL HISTORY

Patient First Name: Middle: Last: Preferred Name:

Patient SSN: Patient Date of Birth:

Address: City: State: Zip:

Home # Work #: Mobile #:

Email Address:

EMPLOYER INFORMATION

Employer Name:

Work #:

SCHOOL INFORMATION

School Name: Phone:

Student Status: part-time or full-time

INSURANCE INFORMATION

Primary Insurance: (circle one) Self Spouse Parent

Insurance Carrier: Group Name: ID#:

Phone number:

Secondary Insurance: (circle one) Self Spouse Parent

Insurance Carrier: Group Name: ID#:

Phone Number:

MEDICAL HISTORY

AIDS/HIV: Yes/ No
Alcohol/Drug Abuse: Yes/ No
Anemia: Yes/ No
Artificial Joint Replacement: Yes/ No
Type _____ Pre-Med Required? _____
Arthritis: Yes/ No
Asthma: Yes/ No
Blood Pressure: High/ Low/ Normal
Blood Thinners: Yes/ No
Cancer/Radiation treatments: Yes/ No
Celiac/Gluten allergy: Yes/ No
Circulation Problems: Yes/ No
Codeine Allergy: Yes/ No
Diabetes: Yes/ No
Excessive Bleeding: Yes/ No
Fainting/Dizziness/Epilepsy: Yes/ No
Heart Murmur: Yes/ No
Heart Attack/ Problem: Yes/ No Pre-Med required? ____

Hepatitis: Yes/ No A__ B__ C__ When? _____
Herpes: Yes/ No
Kidney Problems: Yes/ No
Mitral Valve Prolapse: Yes/ No
Penicillin Allergies: Yes/ No
Pregnant: Yes/ No/ Maybe Due Date ____ Ofc Test ___
Psychiatric Care: Yes/ No
Seizures: Yes/ No
Sickle Cell Anemia: Yes/ No
Stomach Ulcer: Yes/ No
Stroke: Yes/ No
TMJ: Yes/ No
Tobacco: Smoke/Chew/Dip Yes/ No
Tuberculosis: Yes/ No
Other Drug Allergies: _____
Water Supply: Well/ City/ Bottle/ Filter
Other _____

Taking Medications: _____

Any Surgeries/Date: _____

Have you ever taken or are you taking any Bisphosphonate drugs? Yes/ No If yes, ask for SDA consent.
(example: fosamax, boniva, etc., drugs used for bone density)

Medical Physician Name_____ Phone# _____

Emergency Contact Name _____ Phone# _____

Other Important Info: _____

Are you happy with your smile? If not, what would you like to change?_____

What would you like to know more about? Implants Partials/Dentures Orthodontics/Invisalign Sedation Whitening/Cosmetic

Appointment Policy received yes/no ***HIPAA*** received yes/no ***Authorization to Discuss*** received yes/no

Patient or Legal Guardian Signature _____ Date_____

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Authorization to Discuss Information

This form is to be completed by the patient whose protected health information is to be disclosed, or by the parent/legal guardian if the person is under the age of 18, a minor under the S.C. State law.

Print Patient Name _____

Date of Birth_____

I, _____, authorize Simpsonville Dental Associates to discuss and / or release the following personal health information:

(check all that apply):

_____ TREATMENT PLAN(S), X-RAYS, INTRA-ORAL IMAGES
_____ INSURANCE & FINANCES/PAYMENT ARRANGEMENTS
_____ MEDICAL HISTORY
_____ PERSCRIPTIONS
_____ APPOINTMENT(S)
_____ OTHER

with / to the following person(s):

name_____ relation_____ ph# _____

name_____ relation_____ ph# _____

name_____ relation_____ ph# _____

The above information may be released by:_____ phone _____ fax _____ mail

I understand the consent may be revoked by me in writing at any time. I also understand that once the personal health information is released, Simpsonville Dental Associates, PA will not be held responsible for any misuse.

Signature_____
(Patient or Legal Guardian

Print Name_____ Relation _____ Date _____

SIMPSONVILLE DENTAL ASSOCIATES, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME _____

SOCIAL SECURITY #_____

ADDRESS _____

TELEPHONE_____ Email: _____

SECTION B: TO THE PATIENT - -PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. You may obtain a copy of our Notice of Privacy Practices, including any revisions by contacting us:

Phone: (864)963-3601 Mail: 315 W. Georgia Rd. Simpsonville, SC 29681 Email: sda@smiledox.com

We reserve the right to change our privacy policy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact information noted above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving consent to use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature _____ **Date** _____

***If the patient is a dependent or minor*, a personal representative or legal guardian signature, on behalf of the patient, is required below.**

Print Name _____ **Signature**_____

Relationship to Patient _____ **Date** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. ***COPY OF CONSENT IN PATIENT CHART***

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited us from obtaining acknowledgment

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify) _____

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 1/1/03, 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 dentist, 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. By state law, your authorization is valid for 90 days.

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 you 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 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 $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. 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 a 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.

Privacy Officers: Dr. Brooks Godwin, DMD and Dr. Parks Alexander, DMD
Telephone: (864) 963-3601 Fax: (864) 963-2598
Address: 315 West Georgia Road Simpsonville, SC 29681