Welcome to Myser Orthodontics

Scott A. Myser, D.D.S., M.S., P.A.

Patient Information

Patient Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Birth Date _____ SS# _____ Age _____
How did you hear about our office? _____ Patient's Dentist _____

Responsible Party Information

Responsible Party's Name _____ Relationship to Patient _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____ Previous Address (if less than 3 years) _____
SS# _____ Birth Date _____ Drivers License # _____
Employer _____ Number of years _____
Employer's Address _____ Occupation _____

Father/Guardian Name _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
SS# _____ Birth Date _____ Drivers License # _____
Employer _____ Number of years _____
Employer's Address _____ Occupation _____

Mother/Guardian Name _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
SS# _____ Birth Date _____ Drivers License # _____
Employer _____ Number of years _____
Employer's Address _____ Occupation _____

Siblings (Name/Age) _____

Insurance Information

Insured's Name _____ Birth Date _____ SS# _____
Dental Insurance Company _____ Policy # _____ Group # _____
Insurance Company Address _____
Insurance Company Phone _____ Insured's Employer _____
Secondary Insurance Company _____ Insured's SS# _____
Secondary Insurance Company Address _____
Secondary Insured's Employer _____

Emergency Information

Emergency Contact (other than guardian) _____
Relationship _____ Daytime Phone _____ Alternate Ph. _____

I certify that all of the above information is true and it is my responsibility to inform this office of any changes, and that in order to receive complete information on financial options it is necessary for me to authorize a credit report.

Signature (Guardian's signature if a minor) _____ Relationship _____ Date _____

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Health History

Initial Date _____ Update 1 _____ Update 2 _____

MEDICAL HISTORY

Please check Yes or No if the patient has or has ever had...

Y	N	
		Joint Swelling or Arthritis
		Bone Disorders
		Heart Problems
		Diabetes
		Thyroid Problems
		Kidney Problems
		Rheumatic Fever
		Hepatitis or Liver Problems
		Emotional Problems
		Tuberculosis
		AIDS / HIV
		Anemia
		Asthma
		Epilepsy
		Prolonged Bleeding
		Endocrine Problems
		Tonsils Removed
		Adenoids Removed

Please list dates and specifics for all "Yes" answers:

List any allergies:

List any medications presently being taken:

List any serious illness or operation not listed above:

Is the Patient currently under a physician's care? _____
Physician's Name _____
Reason _____

DENTAL HISTORY

Chief complaint: _____

Please check Yes or No if the patient has or has ever had...

Y	N	
		Any injury to face, mouth, teeth?
		Thumb, finger or lip sucking habit(s)?
		Any speech problems?
		Mouth breathing when asleep, awake?
		Any known missing permanent teeth?
		Any known extra permanent teeth?
		Any teeth removed by extraction?
		Tongue thrust?
		Any wind instruments played?
		Clenching or grinding of teeth?
		Chronically sore or bleeding gums?
		Jaw pain, popping, grinding, locking?
		Difficulty chewing or swallowing food?
		Frequent headaches?
		Muscle tenderness or stiffness in neck/jaw?
		Ringing of ear, dizziness?
		Previous treatment for TMJ or joint problems?

Please list dates and specifics for all "Yes" answers:

Does patient visit dentist regularly? _____
Has an orthodontist been consulted previously?
Reason: _____
Has patient experienced a sudden increase in height?_____
Does any member of the family or close relative(s) have a similar arrangement of the teeth or similar appearance of the jaws? Explain:

Please list any other dental information known, and not listed above.

The above information is true to the best of my knowledge, and I understand that it is my obligation to update this information as changes become known to me.

Patient/Parent/Guardian Signature _____ **Date** _____

Patient Notice of Privacy Practices

This notice describes how your medical information may be used and discloses and how you can get access to this information.
This Notice takes effect 10/1/2014 and will remain in effect until we replace it.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is effect. 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, and to make new Notice provisions effective for all health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for a copy of this Notice, please contact us using the information listed at the end of this Notice.

~Uses & Disclosures of Protected Health Information~

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description. Some information, such as HIV-related information, alcohol and/or substance abuse and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We will use and disclose your health information to provide, coordinate, or manage your health care and related services. This includes the coordination of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we will disclose health information to other doctors who may be treating you. In addition, we may disclose your health information to another doctor or health care provider (e.g., a specialist or laboratory) who becomes involved in your care. **Payment:** Your health information may be used to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. You have the right to withhold information from your insurance company if you pay for specific services. To exercise this right, please notify us in writing immediately and in advance of treatment. **Healthcare Operations:** We may use or disclose your health information to support the activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, education and licensing activities. We may also contact you via email or other means to ask you if you are interested in providing information to future patients, such as an online review or other social media / promotional activities. We may provide patient surveys designed to offer us feedback about our services. **Messages & Other Contact Initiated by Us:** By providing your email address and telephone number, you give us permission to email, text, and leave voice messages for you. We may use or disclose your health information to provide you with information about treatment alternatives or other health-related benefits and services. **Business Associates:** We will share your health information with “business associates” that perform various activities (e.g., transcription) for us. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we obtain a written agreement to protect the privacy of your protected health information. **Facility Directories:** We may use and disclose your name, the location at which you are receiving care, and your condition (in general terms). All of this information will be disclosed to people that ask for you by name. **Others Involved in Your Healthcare:** We may disclose to your family, a friend or any other person you identify, your protected health information. If you are unable to agree or object to such a disclosure, we may disclose information if we determine that it is in your best interest. We may use or disclose health information to notify or assist in notifying a family member, representative or any other person that is responsible for your care. Finally, we may use or disclose your health information to an authorized public or private entity to assist in disaster relief efforts. **Emergencies:** We may use or disclose your health information in an emergency treatment situation. If we are required by law to treat you and the doctor has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your health information to treat you. **Communication Barriers:** We may use and disclose your health information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers and the doctor determines, using professional judgment, that you intend to consent. **Required By Law:** We may use or disclose your health information to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. **Public Health:** We may disclose your health information for public health activities and for purposes to a public health authority that is permitted by law to collect or receive the information. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. **Communicable Diseases:** We may disclose your health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition. **Health Oversight:** We may disclose health information to a health oversight agency for activities authorized by law. **Abuse or Neglect:** We may disclose your health information to a public health authority that is authorized by law to receive reports of child abuse or neglect or if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of federal and state laws. **Food and Drug Administration:** We may disclose your health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required. **Proceedings:** We may disclose health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency and it is likely that a crime has occurred. **Coroners, Funeral Directors, and Organ Donation:** We may disclose health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. **Research:** We may disclose your health information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.
Criminal Activity: We may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information, if necessary for law enforcement to identify or apprehend an individual.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized. **Workers' Compensation:** We may disclose your health information as authorized to comply with workers' compensation laws. **Inmates:** We may use or disclose your health information if you are an inmate of a correctional facility and your doctor created or received your health information in the course of providing care. **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

~Your Health Information Rights~

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of health information about you that is contained in a designated record set for as long as we maintain the protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to have this decision reviewed. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a requested restriction. If we believe it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You may request a restriction by notifying the Privacy Contact in writing, describing the reasons for your request. Notice for restriction is to be sent to: Privacy Contact, Northern Texas Facial & Oral Surgery, 440 West Interstate Hwy 635, Suite 445, Irving TX 75063. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact at Northern Texas Facial & Oral Surgery, 440 West Interstate Hwy 635, Suite 445, Irving TX 75063. **You may have the right to have your doctor amend your protected health information.** You may request an amendment of health information about you in a designated record set for as long as we maintain this information. We may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record. **You have the right to receive an accounting of certain disclosures we have made of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. **Electronic Copies of Records:** You have the right to receive health information by email, either encrypted or not encrypted. By sending us an email requesting information, you consent to release of health information via email. **Questions & 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 if you disagree with a decision we made about access to your health information or in a response to a request you made to amend or restrict the use or disclosure of your information or to have us communicate with you by alternative means or 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 against you for filing a complaint.

Myser Orthodontics
311 S. FM 1187, Suite D
Aledo, TX 76008
817-441-8700
info@myserortho.com

Consent for Purposes of Treatment, Payment and Healthcare Operations

I have reviewed a copy of the Patient Notice of Privacy Practices, which describes how my protected health information may be used and disclosed. This notice is available in all offices, at www.myserortho.com and by request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Myser Orthodontics. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my doctor, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information as described in the Patient Notice of Privacy Practices by Myser Orthodontics, Dr. Myser, its employees and staff for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Myser Orthodontics. Healthcare operations may include email reminders, phone calls, and texts and correspondence asking for my feedback or inviting me to share my experiences via surveys and/or social media. I understand that diagnosis or treatment of me by Myser Orthodontics may be conditioned upon my consent as evidenced by my signature on this document. I authorize release of information to my immediate family members, including (as applicable) my parents or guardians, wife, husband, and children. Exceptions to this release are:

_____ (none, if blank).

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Myser Orthodontics is not required to agree to the requested restrictions. However, if my doctor agrees to a requested restriction, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Myser Orthodontics, it's employees, doctors, and staff has taken action in reliance on this consent.

Myser Orthodontics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the website, calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

As a service to our patients, we may provide courtesy appointment reminder or other calls, emails and/or texts. By providing your cell phone number and email address, you consent to receiving such calls/emails/texts.

Signature of Patient or Personal Representative _____Date_____

Name of Patient or Personal Representative_____

Description of Personal Representative's Authority _____