The Dental Co. of Leesburg
17-C Fort Evans Road NE
Leesburg, VA 20176
703-777-5025

Patient Information

Name ________________________________ **Preferred Name** ______________________ **Date** ____________

SS#________-______-______________ **Gender** __M __F __**Married** __**Single** ___**Child**

Birthday___/_____/_______ **Email Address**____

Home#_______________________ **Cell#**________________________ **Work#**__________________

May we call you at work? ____________

How did you hear about us?

____

Address____

Street **City** **State** **Zip**

HEALTH INFORMATION

Date of last Dental Visit:____/______/____

Have you ever had any of the following? Please check all that apply.

___AIDS ___Diabetes ___Abnormal Bleeding ___Dizziness
___Allergy Codeine ___Earaches/Ringing in Ears
___Allergy Latex ___Emphysema ___Allergy Metals ___Epilepsy
___Allergy Rubber ___Excessive Bleeding
___Allergy Other ____________ ___Fainting ___Anemia ___Fever Blister/Cold Sores ___Arthritis ___Gastritis
___Artificial Joints ___Glaucoma ___Asthma ___Growths
___Blood Disease ___Hay Fever
___Blood Transfusions ___Head & Neck Radiation ___Breathing Difficulties ___Head Injuries
___Bronchitis ___Hearing Loss
___Cancer ___Heart Attack ___Chronic Cough ___Heart Disease
___Chemotherapy ___Heart Murmur
___Cirrhosis ___Heart and Valve Defects ___Colitis ___Hepatitis
___Coronary Artery Disease ___High Blood Pressure
___HIV Positive ___Psychiatric Treatment ___Radiation Treatment ___Respiratory Problems
___Rheumatic Fever ___Rheumatism
___Severe Headaches ___Sinus Problems ___Stroke ___Thyroid
___Tuberculosis ___tumor
___Ulcers ___Urinate Frequently ___Jaundice ___Kidney Disease
___Liver Disease ___Mitral Valve Prolapse ___Mental Disorders ___Nervous Disorders
___Pacemaker ___Prosthetic Heart ___Pregnancy Due Date ________ ___Radiation Treatment
___Rheumatic Fever ___Rheumatism ___Sexually Transmitted Disease

Have you been admitted into the hospital or needed emergency care in the past two (2) years? ______Yes ______No
If yes, please explain____
Are you now under the care of a physician? _______Yes ______No
If yes, please explain____
Name of Physician____Phone______________________
Do you have any health problems that need further clarification? _____Yes _____No
Are you taking medication at this time? _____Yes ______No

Medication Name **Dosage** **How Often** **How Long**

____
____
____

- Have you ever had Periodontal treatment? ____Yes ___No
- Are you dissatisfied with the appearance of your teeth? _____Yes _______No

If yes, what would you like to change?____

- Do you smoke? _____Yes _____No Do you chew tobacco? _____Yes ____No
  If yes, how much? ________________________________ How long? ________________________
- Have you ever had an allergic reaction to medical anesthesia? ____Yes ____No
  If yes, what medicine? ____________________________What kind of reaction?____________________
- Do you grind/clench your teeth during the day and night? ____Yes _____No
- Are you interested in teeth whitening? _____Yes ____No
- Have you ever had any trouble associated with dental treatment/surgery/extractions? _____Yes _____No
  If yes, please explain____
- Have you ever had an unusual reaction to dental anesthetic? ______Yes _____No
  If yes, please explain____

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

____ ______________________________

Signature of patient, parent, or guardian **Date**

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ______________________________________

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following info is for: _____the patient's spouse _____responsible party

Name__________________________________ Male or Female ___Married ___Single ____Other
SS#_________________________ Birthday ___________________Phone #________________________________

____

Street City State Zip

EMPLOYMENT INFORMATION

Employer Name:____________________________________Occupation:_______________________________

Address____
Street City State Zip

PATIENT TREATMENT AND CONSENT

I authorize Dr. Wollmann, his associates or designated staff treating me to perform such diagnostic aids deemed appropriate to make it a thorough diagnosis of my dental needs. These initial procedures include but are not limited to oral examination, x-rays, and intra oral pictures. Upon deciding such diagnosis, I authorize the dentist and her associates or designated staff to perform all recommended treatment and therapeutic procedures including administering medication as prescribed by the dentist and mutually agreed upon by me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_Signature____Date____________________________

List of all patients that this financial agreement applies to (please list spouse and kids if you want them included):

____

____

____

____

INSURANCE INFORMATION

Primary

Policy Holder's Name ______________________________ DOB____________

ID# ____________________ Group # ____________________

Policy Holder's Employer ___________________________

Insurance Company Name ____________________

Insurance Company Address ____________________________________

Effective Date of Coverage

Secondary

Policy Holder's Name ______________________________ DOB____________

ID# ____________________ Group # ____________________

Policy Holder's Employer ____________________________

Insurance Company Name ____________________

Insurance Company Address ____________________________________

Effective Date of Coverage_________________

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services or any dental services performed without insurance coverage must be paid in full at the time services are rendered.

Your agreement with the insurance company is between you and your insurance company. Any assistance by the doctor and/or staff in filing of insurance papers or confirmation of insurance payments is strictly given as a courtesy and implies no responsibility on their part for follow up confirmation. If the insurance company does not remit payment within 60 days after the date of service, we will bill you with the remaining balance due and payable upon receipt from you. A 1.5% charge per month will be added to the unpaid balance unless an arrangement has been made in advance with our billing specialist. We are happy to file necessary forms to ensure that you receive full benefits of your policy, but make no guarantee of payments or any estimated coverage.

This signature on file is my authorization to release any information to the insurance company to process my claim. I hereby authorize payment of my group insurance benefits to the dentist if any claims were filed by the dentist. I hereby certify that I fully read the above and agree with all terms and conditions.

_________________________________printed name

_________________________________ date

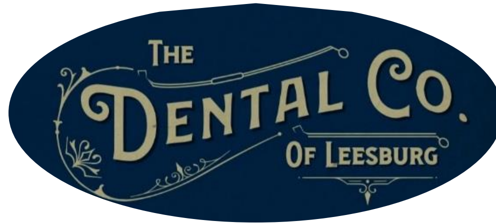
Printed Name of Patient/Parent/Guardian Date

______________________________________ signature

_______________________________________email

Signature of Patient/Parent/Guardian email address

____



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.

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 in effect. This Notice takes effect 3/1/2015, 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, and to make new Notice provisions effective for all protected 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 additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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 and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, 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 may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.
Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

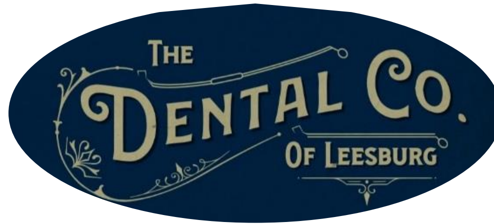
Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.
Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.
Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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: Josef Wollmann
Telephone: 703-777-5025
Fax: 703-777-4106
Email: drjwollmann@leesburgdentist.com
Address: 17-C Fort Evans Road NE Leesburg, VA 20176



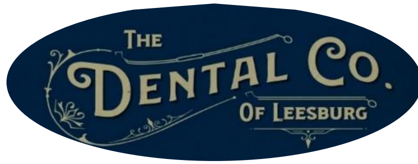
I ____________________________________, hereby authorize The Dental Co. of Leesburg. or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face . I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, contest, etc). I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs or videos. If I wish to revoke this consent, I may do so in writing. If declining this consent, leave blank. Please initial one option:

_____I do not mind if my photographs/video are used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

Patient Name:_________________________________

Signature:____Date____________



ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I have received and read a copy of Dr. Wollmann's Notice of Privacy Practices.

____
Please print your name

____
Signature

____
Date

In Office Use Only
______Individual refuse to sign
______Communication barrier prevented obtaining the acknowledgement
______An emergency situation prevented obtaining the acknowledgement

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parent, or others to call and request the results of tests and procedures. Under the requirements for H.I.P.A.A., we are not allowed to give this information to anyone without the patients consent. If you wish to have your information released to family members you must authorize and sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow The Dental Co. of Leesburg to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

1. Name________________________________Relationship to Patient __________Date_______________
2. Name________________________________Relationship to Patient ____________Date_______________

Messages

Please Call: [ ] my home [ ] my work [ ] my cell number: __________________________

If unable to reach me:

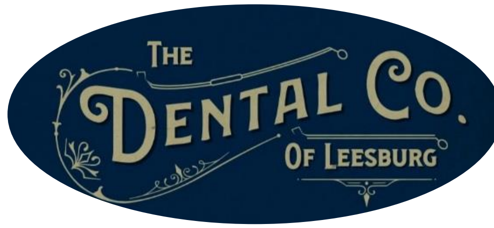
[ ] you may leave a detailed message
[ ] please leave a message asking to return your call
[ ] ____

The best time to reach me is (day)______________between (time)_______________

From time to time it is necessary for representatives of The Dental Co. of Leesburg to leave a message for patients. The purpose of these messages is to remind patients that they have an appointment, notify the patient that the staff would like to discuss lab or procedure results or to ask a patient to call the office regarding an issue or concern. At no time will a representative of The Dental Co. of Leesburg discuss your medical circumstances without your consent. The purpose of this consent is to leave a message with members of your household or on your answering machine.

You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

______________Authorize **_______________Not Authorized**



The Dental Co. of Leesburg
Financial Agreement

Payments:

I understand that all estimated copayments, applicable deductibles and (insurance related) non covered services are due at the time services are rendered. I understand that as a guarantor on the account of a dependent I am also responsible for the afore-mentioned copayments. __________

I understand that my own personal and any guardian related account balance must be paid within 10 business days of any statement received unless a signed payment agreement has been made between myself and the financial representative of" The Dental Company of Leesburg". Any account balance is considered delinquent and subject to outside collection after 45 days past due. It is the Guarantor responsibility to give updated billing information to the administrative team to ensure you are receiving timely statements, via e-mail and physical address __________

I understand that I may be asked to "pre-pay" for services if they are related to "custom services, outside lab charges, or services that require over 60 minutes of the providers reserved time. A guarantor may also be asked for pre-payment in the event of past delinquent account status_________

I understand that a missed payment in a payment agreement creates a void of contract. A payment is considered "missed" after 48 hours of the agreed payment date and it is the sole responsibility of the guarantor to contact our office if there is a change in the credit card affiliated with any payment agreement. ___________

Insurance:

As a courtesy to our patients, our administrative team will perform a "complimentary benefits check" with proof of insurance. Our administrative team will also provide an "estimated coverage of recommended treatment" based on the benefits check. The administrative team agrees to offer the additional complimentary service of filing your insurance claim with the following factors considered and agreed upon:

- The insurance policy and related coverage is a contract between the insured and the administrator of the plan (often the employer) ANY service partially paid or unpaid by the insurance is payable by the guarantor once the claim has processed.
- The insured is responsible for giving updated policy information to the administrative team PRIOR to services rendered as well as notifying the office in the event of the insurance policy termination.
- The insured is responsible for ANY policy limitation related to services rendered. It is strongly advised to read all insurance policy information related to your plan prior to using the plan.
- Most insurance claims process within 30 days. In the event of delayed claim payment or a change in our ability to become compensated by the claim filed, the claim will be closed after 60 days and the guarantor is responsible for payment in full.

It is our intention to assist you with your questions or concerns related to your insurance policy however our administrative team is in no-way responsible for ensuring payment of claims filed on your behalf. It is our intention to combine our knowledge and experience with facilitating a seamless billing process, your communication and participation is appreciated and we are not responsible for error or omission of information ._________

I agree to the above terms regarding my presented insurance coverage, claim filing and requested co-payments. I understand that insurance claims and supporting information will be filed on my behalf by the administrative team of The Dental Company of Leesburg and I agree for payment to be assigned to the Owner Dr. Josef Wollmann DBA as Nova Lifesmiles PLLC. __________

Cancellation Policy:

In the event of reschedule or cancellation of an appointment a 48 hour notice is required preferably by speaking with a member of our admin team. The Dental Company reserves discretionary right to charge a $50 fee if notice is not received that must be paid prior to making a future appointment. ____________

Patient's Name____________________________________
Date____

Signature____
Patients Name____