Inna Kost D.M.D. M.Sc.
10401 Old Georgetown Rd., #103
Bethesda, MD 20814
(301) 530-6195

Welcome to our practice! This document contains the information required by law and many Health Plans to protect your rights, inform you of your rights and responsibilities. We are sorry that it is of such length, but we must comply with the terms and conditions that are imposed upon us so that we may serve you. By signing this form you are granting consent, authorizing and agreeing to the following terms and conditions:

Our Notice of Privacy Practices: I acknowledge receipt of Privacy Practices, which provides more detailed information about how Dental One LLC may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this clause, and we encourage you to read it in full. You may obtain a copy of the current and revised notice by contacting our office. You may also take a written copy of the notice with you. You do not need to acknowledge receipt of our notice in order to receive care. Initials: _____Date: ____/____/_____

All Other Insurance Companies and/or Third Party Payers: I HEREBY AUTHORIZE Dental One LLC and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Dental One LLC rendering the service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Guarantee of Payment: I UNDERSTAND that filing a claim with my insurance company or other third party payer, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Dental One LLC to me or the patient as indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. But is not limited to, claims filed for Workers' Compensation and/or other claims due to personal injury accidents/illnesses, which physicians, suppliers, and practitioners will bill and collect separately for their services. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment either because the plan deems such services not medically necessary or for any other reason.

Consent to Treat: I, as the legal guardian and legal representative of the minor named below, authorize and request Dental One LLC, to provide medical care to the child or minor reasonable by today's standards at Dental One LLC.

I hereby AUTHORIZE examination and dental treatment for the diseases for which I have consulted this practice.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

PATIENT SIGNATURE DATE

_____ _____

(if patient is 18 years or older, his/her signature is required in addition to the "responsible party")

RESONSIBLE PARTY (if other than the patient) DATE

_____ _____

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WELCOME TO BETHESDA PRACTICE!

PATIENT INFORMATION

TODAY'S DATE: _____

Patient Name: _____

Patient's Address: _____

_____

_____

Patient's Age: _____ Sex: _____

Patient's Date of Birth: _____

Patient's Social Security #: _____

Patient's Phone #: _____

Cell Phone #: _____

Marital Status: _____

INSURANCE INFORMATION

Name of Insured: _____

Address: _____

_____

Employer: _____

Address: _____

_____

Insurance Company: _____

Address: _____

_____

Relationship to Patient: _____

Date of Birth: _____

Social Security #: _____

Phone: _____

Union or Local #: _____

Group #: _____

Phone #: _____

Member #: _____

Family / Single Coverage: _____

ADDITIONAL INSURANCE

Name of Insured: _____

Employer: _____

Insurance Company: _____

Address: _____

_____

Relationship to Patient: _____

Social Security #: _____

Date of Birth: _____

Phone: _____

Group #: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

- ❑ Insurance
- ❑ Internet Search
- ❑ Family / Friend _____ *name*
- ❑ Printed Ad _____ *publication*
- ❑ Other _____ *please specify*

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PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____ Date of Last Exam: _____

Have you ever been told you have one of the following? Check only if answer is yes.

___ Heart Disease	___ Anemia	___ Asthma
___ Heart Attack	___ Bleeds Easily	___ Shortness of Breath
___ Heart Murmur	___ Fainting/Seizures	___ Swollen Ankles
___ Chest Pain –Angina	___ Epilepsy/ Convulsions	___ Hay Fever/Allergies
___ Congenital Heart Defect	___ Arthritis	___ Emphysema
___ Rheumatic Fever	___ Joint Replacement/Implant	___ Recent Weight Loss
___ High Blood Pressure	___ Liver Disease	___ Diabetes
___ Low Blood Pressure	___ Hepatitis	___ Cancer
___ Stroke	___ Jaundice	___ Radiation Therapy
___Thyroid Disease	___ Glaucoma	___ Psychiatric Treatment
___ Stomach Ulcer	___ Leukemia	___ Other _____
___ Mitral Valve Prolapse	___ AIDS/HIV	_____
___ Sexually Transmitted Disease	___ Kidney Disease	_____

Yes NO

___ ___ 1. Are you under medical treatment now? Why: _____
___ ___ 2. Have you ever had any other serious illness not listed above? What: _____
___ ___ 3. Are you currently taking any medications? What: _____
___ ___ 4. Have you ever had a bad reaction to local anesthetic or penicillin? What: _____
___ ___ 5. Do you use tobacco? _____
___ ___ 6. Do you use Alcohol, Cocaine or other drugs? What: _____
___ ___ 7. Women Only: Are you pregnant or think you may be pregnant? What month:_____
Are you taking birth control pills? _____

PATIENT DENTAL HISTORY

What is your reason for seeking care at this time: _____
Do you have regular dental checkups? When was your last dental exam: _____
Do you have any pain or discomfort now? What: _____
Do your gums bleed? _____ Have you had surgery preformed on your gums? _____
Have you ever had a root canal? _____ Have you ever worn braces? _____ Do you wear Dentures?_____
Do you grind your teeth?_____ Have you ever had any trauma to your face or mouth? _____
Do you floss? How often? _____ How many times a day do you brush your teeth? _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

All information is HIPPA compliant and will only be disclosed for medical or dental treatment.

_____ Date: _____
Signature of Patient/Parent or Guardian

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FINANCIAL POLICY

Our goal is to provide patients with the best dental care available in a comfortable atmosphere. Part of that care involves a financial relationship between you and our office. We hope this information will clarify our financial policy and your obligation for your dental care.

INSURANCE: As a courtesy to all patients we will verify your dental insurance benefits. You are responsible to know your plan coverage, exclusions and limitations.

All insurance claims will be billed immediately and those that have not been paid within 45 days, or any balance that your insurance provider does not pay, will be billed directly to you. That balance will be due immediately and considered late if not paid within 15 days. Any balance due that has not been paid within 60 days of the original billing date may be sent to a collection agency and a $95 processing fee or more will be added to your account.

Please understand that our treatment recommendations are not based on what your insurance pays, but on what Dr. Inna Kost feels is the most appropriate for you after consulting with you. Insurance benefits are determined by your employer and the insurance company and such decisions are usually based on costs. So they may eliminate coverage for some procedures or ask you to pay for a larger portion of the bill. We have no control over that.

We are committed to making the financial part of your dental experience as comfortable as the treatment part. Working with insurance is not always easy but we will help you with it. Thank you for fulfilling your responsibility by caring for all financial obligations in a timely manner.

The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, MasterCard, American Express, or Discover. To help you accept an extensive treatment plan, we are offering a Care Credit dental treatment Financing Program. All estimates are subject to final approval by your dental insurance plan. Therefore the amount due is subject to change after final explanation of benefits have been paid. **(initialize)** _____

INTIAL PAYMENT FOR DENTAL TREATMENT: Most plans are covered for routine clinical exam cleaning. No deductible is due for diagnostic or preventative treatment unless otherwise stated. Deductibles for basic/major services customarily include fillings, crowns, extractions, root canal therapy and periodontal treatment.

- Deductibles are usually $50-100 per individual up to $200 per family annually
- 20 % co-payment for all basic services
- $450 for any build-up & crown procedures. Most Plans do not allow separate benefits for crown build-up. In such a case the patient is responsible for the full cost of build-up.
- Lab fee is an additional cost discounted plans such as Ameriplan ($140.00/crown). Careington ($150.00/crown). Mamsi Federal Gov ($122.00/crown) and some other plans. It can also be offered to you as an optional for restorations requiring specific materials or advanced techniques (veneers, all porcelain crowns, porcelain margins, etc.) You will be advised on any additional lab cost prior to the start of treatment.
- Implant surgery Pre-payment of $350.00 at the time of scheduling a appointment for implant placement. Full payment of balance at the time of implant placement.

(initialize)_____

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- SCRT (deep cleaning treatment) $50.00 pre-payment at the time of scheduling appointment.

PROVISIONAL CROWNS: The laboratory fee for a temporary crown is $250.00. Patient is responsible for payment at the time of treatment.

(initialize)_____

RESIN-BASED COMPOSIT RESTORATIONS (Fillings): Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for the less expensive treatment (silver/mercury based restoration). For the best of our patients, we recommend and we place only composite-based ("white") fillings. The difference is usually $50-$70 per filling and the patient is responsible for the difference in cost. Please ask the front desk or doctors if you need more information about composite "white" fillings.

(initialize) _____

FINANCIAL CHARGES: All returned checks are subject to $25 fee. All balances over 90 days are subject to interest in amount of 1.5% per month mandated be State law. We reserve the right to apply $20 rebilling fee and $25.00 late charges toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau. **(initialize)** _____

PAST DUE ACCOUNTS: In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all the fees including and not limited to attorney fees, court costs, and collection agency fees. **(initialize)** _____

MISSED APPOINTMENT FEE: Please note that there is a missed appointment fee of $50.00 per hour for all appointments not given at least 24 business hours notice. Please give us a call in advance if you need to reschedule or cancel your appointment.

(initialize) _____

TRANSFERRING RECORDS: You will need to request in writing if you would like us to mail, fax, e-mail, etc, any part of your records with DENTAL ONE LLC. We need at least 3 business days. If your record is more than two years old and is stored in a company's archive the cost of duplicated/printed x-rays is $5.00 for a single PA x-ray. $15.00 for Bite-wings. $25.00 for a full mouth x-ray and $25.00 for a panoramic film. Coping and printing fees are $10.00 per record. No fees charged for emailed x-rays. The fee waived if we are referring you to specialist. **(initialize)** _____

This is an Agreement between Dental One LLC, as a provider of professional services and creditor, and the patient/debtor named on this form. By reading and signing this Agreement, you are agreeing and accepting this policy in full.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION:ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION;I UNDERSTAND AND AGREE TO ALL POLICIES OF DENTAL ONE LLC.

Print Name _____ (PATIENT/SUSCRIBER, if minor-Guardian)

SIGNATURE _____ **DATE** _____

HIPAA

How We Protect and Keep Your Health Information Confidential

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 04-14-03and 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 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.

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

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 use or 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 will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

How We Protect and Keep Your Health Information Confidential

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.

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RECORDS REQUEST AUTHORIZATION FORM

Records Request Authorization Form

I herby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

_____

Person or entity requesting the information and authorized to make the requested use or disclosure:_____

Recipient of this information: _____

This information is being requested for the following purpose(s):

_____

This authorization shall remain in effect form the date signed below.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (expect to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment)

Patient Name: _____ Signature: _____ Date: _____

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

Date:_____