TIME 10:42 AM DATE 12/13/2021

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

LAST CMX

LAST PAN X

LAST BITEWINGS

LAST MEDICAL UPDATE

Eff Date - Primary

Eff Date: Secondary

Referred By

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Health Insurance Portability and Accountability Act (HIPAA)

The Foleck Center
201 College Place Suite #111, Norfolk, VA 23510
1436 S. Independence Blvd, Virginia Beach, VA 23462
2400 Cunningham Drive Suite #100, Hampton, VA 23666
3834 Kecoughtan Road, Hampton, VA 23669

This notice describes how medical information about you may be used & disclosed, & how you can get access to this information. Please review it carefully.

We respect our legal obligation to keep health information that identifies your private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information & what rights you have regarding it.

TREATMENT, PAYMENT, & HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or healthcare operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, examining your teeth, asking you about your medical history, prescribing and filling medications, referring you to another doctor or clinic for other healthcare or services, getting copies of your health information from your former healthcare provider. Examples of how we use or disclose your health information for payment purposes are:, forms of payment for dental services, preparing and sending bills or claims, or collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Healthcare operations" mean those administrative & managerial functions that we have to do in order to run our office efficiently. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance, personnel decisions, participation in managed care plans, defense of legal matters, business planning, and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside our office for these reasons, we will ask for your written permission prior to doing so.

We will not ask for special written permission in the following situations: calling in your prescriptions and discussing your treatment with another dentist/physician.

USES & DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us, and some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance, and notification to/from the Federal Food & Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors, audits by Medicare or Medicaid, or for investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a deceased person or to determine the cause of death, or to funeral directors to aid in burial, or to organizations that handle organ or tissue donations, or disclosures for health-related research.
- Uses and disclosures for specialized government functions, such as for the protection of the president of high ranking government official, for lawful national intelligence activities, for military purposes, or for the evaluation & health of members or the foreign services.
- Disclosures of de-identified information.

- Disclosures relating to workers' compensation programs.
- Disclosures of a "limited data set" for research, public health, or healthcare operations.
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments or when it is time to schedule an appointment. We may also call or write to notify you of other treatments or services available at our office. Unless you tell us otherwise, we will mail you an appointment reminder on a post care, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES & DISCLOSURES

We will not make any other uses of disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation, you will give us a properly completed authorization form (you do not have to sign it). If you do not sign the form, we cannot make the use or disclosure; however, you may revoke it at any time unless we have already acted in reliance upon it if you do sign one. Revocations must be in writing. Send them to the office contact person at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses & disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, & if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, & instructions about how to get an impartial review of our denial if one is legally available. By law, we have one 30 day extension of the time for us to give your access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received the wrong information, & others that you specify. If we do not agree, you can write a statement of your position, & we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position &/or our rebuttal is included in your health information, we will send it along whenever we make time to consider a request for amendment if we notify you in writing the extension. If you want us to ask us to amend your health information, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period of time if you want). By law, the list will NOT include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; & some other limited disclosures. You are entitled to them in advance. We will usually respond to your request within 60 days of receiving it,

but by law we can have one 30 day extension if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.

- You can receive additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you received one electronically or paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose the change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, & post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you may complain to us or the U.S. Department of Health & Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, contact Tanja Manojlovic, our practice manager, at tanja@thefoleckcenter.com or at one of our offices.

Health Insurance Portability and Accountability Act (HIPAA)

The Foleck Center

201 College Place Suite #111, Norfolk, VA 23510
1436 S. Independence Blvd, Virginia Beach, VA 23462
2400 Cunningham Drive Suite #100, Hampton, VA 23666
3834 Kecoughtan Road, Hampton, VA 23669

Address: _____

Email Address: _____

Phone Number: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Foleck Center's Notice of Privacy Practices.

Patient Name (printed): _____

Patient (or Guardian) Signature: _____ Date: _____

FINANCIAL ARRANGEMENTS

PAYMENT OPTIONS

Cash or Check: We accept payment by cash or check at the time of service.
Credit Cards: We accept MasterCard, Visa, Discover, American Express, & all debit cards.

Ask our Financial Manager about financing options through Care Credit.

Payment is due in full at the time of the treatment.

INSURANCE

We are happy to file the necessary forms so that you receive the full benefits of your coverage. However, we can make no guarantee of any estimated coverage because the insurance policy is an agreement between you & the insurance company. Our office will do everything possible to assist you in receiving the full benefits of your policy. We do require all patients to be directly responsible for all charges.

AUTHORIZATION & RELEASE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence & it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services for my treatment and/or diagnosis. I agree, should the occasion arise, to be responsible for cost of collection regarding any past due account; including 33.33% attorney & court fees.

CANCELLATION POLICY/MISSED APOINTMENT POLICY

1) As a courtesy to you, we will make every effort to confirm your reserved appointment. But please do not consider it our responsibility to do so. If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us two business days in advance to change or cancel the reserved time.

2) All patients who fail to arrive for their reserved appointments or who cancel without **two business days** advance notice will be charged a missed appointment fee of **$50.00**. Please note that this missed appointment fee is NOT covered by any insurance plans and is your responsibility to pay. Fees shall be waived only for unforeseen circumstances at Doctor's discretion.

3) If a patient is more than 15 minutes late arriving to their appointment, they will be charged a cancellation fee and will have to be rescheduled.

We strive to accommodate the scheduling needs of our patients, and we will make every effort to keep your schedule on time. We thank you for your cooperation and understanding.

Patient Name (printed):_____ **Date:**_____

Patient (or Guardian) Signature: _____

NOTICE OF DEEMED CONSENT FOR HIV, HPB, & HPC TESTING

As a health care provider, we are required by Section 32.1-45.1 of the code of Virginia (1950) as amended, to give you, the patient, the following notice:

If one of our health care professionals, workers, or employees should be directly exposed to your blood or bodily fluids in a way that may transmit disease, your blood will be tested for infection of Human Immune Deficiency Virus (HIV, the AIDS virus). The blood will also be tested for the presence of Hepatitis B & Hepatitis C viruses. A physician or other health care provider will notify you, and that individual, the results of the test and provide counseling, if necessary.

If you should be directly exposed to blood or bodily fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that individual's blood will be tested for infection with Human Immune Deficiency Virus (HIV, the AIDS virus), Hepatitis B, and Hepatitis C viruses. A physician or other health care provider will tell you, and that individual, the result of the test and provide counseling, if necessary.

The Notice of Deemed Consent for Testing has been explained to me. I have received copy and I accept the terms. For patients under 18 years of age, the responsible party's signature authorizes any necessary testing.

Date: _____

Patient / Legal Representative: _____

Witness: _____

SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS;

2. ENSURE PAYMENT FOR SERVICES PROVIDED

3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS

4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Adam S. Foleck. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____

Patient Full Name (printed) _____

Parent Signature (if minor) _____

Witness _____

Date Signed _____

THE FOLECK CENTER

Cosmetic, Implant & General Dentistry

Photo & Video Release Form

I, _____(printed name), grant The Foleck Center, its representatives and employees the right to take photos and/or videos of me in regards to the treatment and services I receive at their facility for the purpose of publication, promotion, or advertising in any manner or in any medium, including print or electronic.

I grant permission to The Foleck Center to copyright and use such photos and/or videos with or without my name, for the purpose of advertising, illustration, web content and publicity without restriction. I understand that I will not receive any compensation for the use of such pictures or videos taken by The Foleck Center.

I acknowledge that I have read and agree to the above photo and video release form:

Signature: _____
Signature of Parent or Guardian (if under 18):_____
Address: _____
_____
Date: _____

I acknowledge that I have read the above photo and video release form and respectfully decline.

Signature: _____
Signature of Parent or Guardian (if under 18):_____
Address: _____
_____
Date: _____