ENDODONTIC SERVICES

WELCOME PACKET

Welcome to Endodontic Services Inc., office of Dr. Michael Feltman and Dr. Scott Risser. Our office goal is to surpass our patient expectations and provide you with a great experience for your endodontic needs. Our office will remain in contact with your general dentist during your visit and provide your general dentist with a full clinical prognosis of any before and aftercare that may be necessary.

Our office has been in practice since 1972 and provided services for the Northern Indiana area. We incorporate the latest technology with state of the art equipment to provide you with the best possible care. Dr. Feltman and Dr. Risser's combined experiences have allowed our office to provide services to even the most difficult cases, delivering the best results for tooth survival.

Working along side with your general dentist, we strive to provide excellent communication skills to our patients so they can feel confident during the transition from one office to another. Please feel free to read additional information about our services at our website www.endododonticservicesinc.com.

In this packet you will be provided with the following materials:

1. **Our online paperwork-** Most patients find it easy to complete and find it a time saver
2. **A patient's guide to dental insurance coverage-** we understand all the questions and concerns you may have regarding the financials of coming to a new office.

We request that you bring up any additional questions to our office personnel during regular office hours.

Notice of Privacy Policy

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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The privacy practices described are currently in 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 law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary, to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Research:** We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).
- **Other Authorizations:** 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 authorization, you may revoke it 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.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

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.
  We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.

- **Accounting of Disclosures:** 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. 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 will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be 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 must explain the reason for the amendment.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address 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 HHS.

HIPAA COORDINATORS: Scott E. Risser (Endodontist), Lindsey Carter (Office Manager)

Address: 225 North Notre Dame Avenue, Ste 2, South Bend, IN 46617

Telephone: (574) 232-5866

Fax: (574) 287-8891

Email: info@endodonticservicesinc.com

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Signature: _____

Patient Name: _____

Patient Representative (if minor): _____

TODAYS DATE: _____ **PATIENT REGISTRATION** **CHART NUMBER**_____

PATIENT'S FIRST NAME	INITIAL	LAST NAME		PREFERS TO BE CALLED
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE		WORK PHONE		CELL PHONE
SOCIAL SECURITY NUMBER		DATE OF BIRTH		
EMAIL	□ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ OTHER			□MALE □FEMALE

IF PATIENT IS A MINOR PLEASE FILL OUT:			
PARENT OR GUARDIAN NAME		RELATIONSHIP:	
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	EMAIL	
WHO DOES THE CHILD RESIDE WITH?	□ MOTHER □ FATHER □ GRAND PARENT □ OTHER		

PLEASE PROVIDE ADDITIONAL CONTACT INFORMATION:			
EMERGENCY CONTACT PERSON	PHONE NO.	EMAIL	
ADDRESS	CITY	STATE	ZIP CODE
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU		PHONE NO.	RELATIONSHIP:
WHO MAY WE THANK FOR REFERRING YOU?		DENTISTS NAME:	

OTHER: □ BUILDING SIGN □ MAILER/ADVERTISEMENT □ INSURANCE COMPANY □ YELLOW PAGES □ DENTIST

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
INSURANCE COMPANY:		INSURANCE COMPANY:	
EMPLOYER NAME:		EMPLOYER NAME:	
INSURED NAME:		INSURED NAME:	
INSURANCE - ADDRESS:		INSURANCE - ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
DATE OF BIRTH:	GROUP#	DATE OF BIRTH:	GROUP#
RELATIONSHIP TO PATIENT:		RELATIONSHIP TO PATIENT:	
MEMBER ID#:		MEMBER ID#:	
INSURANCE PHONE#:		INSURANCE PHONE#:	
SOCIAL SECURITY NUMBER:		SOCIAL SECURITY NUMBER:	

Our office policy requires that a portion of your bill be paid when treatment is started and the balance must be paid by the time treatment is completed, which is usually the second appointment. Please advise our receptionist if other arrangements are necessary, BEFORE SEEING THE DOCTOR. Charges not paid within 30 days will have a service charge of 1.5% per month (Annual Rate 18%) added to the past due balance on each statement thereafter.

I agree to be responsible for any charges not paid by my insurance company.

Date:_____ **Signature:**_____

MEDICAL HISTORY UPDATE

Do you have a fever? _____
Respiratory Distress? _____
Headache? _____
Dry Cough? _____
Shortness of Breath _____

Our dental team is trained to treat you based upon the questionnaire above and will be taking your temperature reading today. Please reply to this truthfully to help protect you and our staff so that we can provide extra-protection measures according to COVID-19 recommendations.

Physician's Name: _____ Phone Number: _____
Have you had any serious illness or operations? o YES o NO
If Yes, Describe: _____
Have you ever had a blood transfusion? o YES o NO If Yes, Describe: _____
Are you Pregnant? □ YES □ NO Nursing? o YES o NO Taking Birth Control Pills? □ YES □ NO

CHECK (√) YES/NO IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Anemia	□	□	Cortisone Treatments	□	□
Arthritis, Rheumatism	□	□	Diabetes	□	□
Artificial Devices/Joints	□	□	Epilepsy	□	□
Asthma	□	□	Fainting	□	□
Autoimmune Conditions	□	□	Glaucoma	□	□
Bleeding Problems	□	□	Headaches	□	□
Blood Disease	□	□	Heart Problems	□	□
Cancer	□	□	Heart Surgery	□	□
Chemical Dependency	□	□	Hepatitis	□	□
Chemotherapy	□	□	High Blood Pressure	□	□
Circulatory Problems	□	□	HIV/AIDS	□	□

	YES	NO		YES	NO
Jaw Pain	□	□	Sleep Apnea	□	□
Kidney Disease	□	□	Snoring	□	□
Liver Disease	□	□	Stroke	□	□
Nervous System Problems	□	□	Swelling Feet/Ankles	□	□
Osteoporosis	□	□	Thyroid Problems	□	□
Pacemaker	□	□	Tobacco Habit	□	□
Psychiatric Treatment	□	□	Tuberculosis	□	□
Radiation Treatment	□	□	Ulcer	□	□
Shortness of Breath	□	□	Skin Rash	□	□

MEDICATIONS/ALLERGIES:

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES TO :	YES	NO
Aspirin:	□	□
Penicillin:	□	□
Codeine:	□	□
Local Anesthetic:	□	□
Sulfa:	□	□
Latex	□	□
Other:	□	□
Barbiturates:	□	□

Signature of Patient, Parent, or Guardian:

_____

Date: _____

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGEMENT FORMAT

PURPOSE: This form is to obtain an individual's permission for (a) our use of the individual's patient health care records to carry out treatment, payment activities, and health care operations. This consent is a condition of your treatment by us. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of uses and disclosure of your protected health information (PHI) and of other important matters about your protected health information.

How do you want to be acknowledged when being summoned from the reception area (please check one):

_____By First Name Only _____By Proper Sir Name (Mr. Mrs. Ms. With Last Name _____Other

Please list any other parties that can have access to your health information, patient records, and all other (PHI) protected health information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OUR NOTICE OF PRIVACY PRACTICES ARE INCLUDED IN THIS CLIPBOARD, DISPLAYED AT THE FRONT DESK, AND ARE AVAILABLE FOR REVIEW ON OUR WEBSITE: WWW.ENDODONTICSERVICESINC.COM

OUR DISCLOSURE OF DENTAL INFORMATION/OTHER CONSENT:

I, (print your name) _____have been informed of this office's Notice of Privacy Practices. I understand by signing this form, I am confirming my written permission for the disclosure of my protected health information. (PHI)

Signature: _____ Date: _____

Parent/Legal Guardian (if minor):

_____ Date: _____

Endodontic Services, Inc.

225 North Notre Dame Ave. St 2
South Bend, IN 46617

117 ½ South Nappanee Street
Elkhart, IN 46514

FINANCIAL POLICY

We offer several different payment methods and options in order to serve the best interests of our patients and practice.

PLEASE CHECK WHICH OPTION YOU WILL BE UTILIZING BEFORE TREATMENT:

_____ **Payment in Full**- We accept Credit Cards (VISA, MC, DISC, AMEX), Care Credit, Cash, or Checks. Should you carry dental insurance and pay in full at the time of your service, all dental payments received will be sent back to you. Refunds are in "check" format and will be mailed to your address on file.

_____ **2 Payment Option**- Pay 50% towards full fee and the other 50% before 30 days, interest free.

_____ **Care Credit Finance Company**- We have a special arrangement with Care Credit for our patients, upon approval of application.

_____ **Patients with Dental Insurance**- As a courtesy to you, we would be happy to submit your claim to your insurance company. Our office requires a 35% copayment amount due at the date of service and our submission will help maximize your insurance benefits. The insurance policy constitutes an agreement between the carrier and the patient. Our office cannot make a guarantee of estimated coverage or payment. Thus, any non-covered procedures or balance after dental insurance will be due within one billing cycle. We will do everything we can to help each patient get the full benefits from your individual policy or policies if you carry dual coverage.

Please Note: Should an individual receive payment directly from their coverage, the charges at the date of service are due in full.

Non-Payment of Procedures-

a. In the event a patient does not pay for services in one billing cycle, a finance charge of 1.5% will accrue will be billed out based on the final balance.
b. In the event your balance becomes 90 days or more overdue, our office serves the right to send your account to a collection company. The patient will then be responsible for making financial arrangements through the collection company or pay for services in full through our office. If payments are satisfied, our office will report all amounts received to the collection company (American Profit Recovery).

I have read and understand the above financial policy at Endodontic Services, Inc.

(Printed name)

_____

(Signature)

_____

(Date)

_____

CONSENT FORM

You are here for evaluation and possible treatment of a tooth with root canal therapy. Root canal therapy or Endodontics is 95% successful and the cost of this treatment includes all pre-op diagnosis, root canal therapy, and all postoperative care.

Of the 5% that do not heal, follow-up treatment involving a small surgical procedure may be necessary. This procedure will be an additional fee. Again, all diagnosis, treatment, and post-op care for the surgery will be included in the surgical fee.

Please feel free to talk to Dr. Risser, Dr. Feltman, and their office staff today during your appointment regarding any questions that you have about the procedure, fees, payment arrangements, and insurance questions, or appointments.

Kindly give our office 24 hours' notice before cancelling or rescheduling of any dental appointments. If you fail to give us this courtesy, a $45 broken appointment fee will be added to your account.

I hereby acknowledge and understand that there may be an increased risk of COVID-19 may be transmitted in any place of public accommodation, which includes my dentist's office. I have been informed by my dentist of his/her desire to protect their patients, staff, and the community at large.

We are taking every precaution necessary to limit the exposure of any virus within our office.

I understand that despite my health care providers best efforts to identify potential carriers of the virus, we cannot guarantee that we are able to identify such individuals and prevent them from potentially brining the virus to this office. Despite safeguards instituted to minimize infection. I understand that there is a risk that performing this procedure, and the care associated with it, may result in my becoming infected with the COVID-19 virus. Such infection could further result in significant sickness, disability, or death.

I further consent to administration of the local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug responses (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g., irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves with may be caused by injections of any medication or drug.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications includes bleeding, swelling, bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth or lip tissues), jaw fractures, sinus exposure, and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that despite the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation of procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow all instructions as explained and directed to me and permit prescribed diagnostic procedures.

Patient or Guardian's Signature _____

Date of Service _____

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