OUR FINANCIAL POLICY

Thank you for choosing Skylight Dental Care as your dental care provider. Please thoroughly read and sign our policy agreement.
Payment is due in ***full*** at the time services are rendered to you as well as any individual for whom you are financially responsible for. Payments can be made via cash, check, credit cards, and money orders. There is also the option for flexible financing, with approved credit.
We cannot bill your insurance company unless you have provided us with your complete and accurate dental insurance information. As a courtesy, we will attempt to verify your policy. Your insurance policy is a contract between you and your insurance carrier. Please make yourself aware of what your insurance plan consists of; this includes your yearly maximums and deductibles. Also, be aware that some, and perhaps all, of the services provided may be considered "non-covered" services and/or not considered reasonable and necessary under your dental insurance. Again, all co-pays and deductibles are due at time services are rendered.
Insurances are filed when a social security number is provided, if you choose to not provide us with your social security number, you will be responsible for the full payment of services rendered. We require social security numbers as well as a valid government issued picture identification. They are for proper record keeping, and you will not be seen if you do not have a valid form of identification.
Although treatment plans are given with an ***estimated*** patient balance on the date of service, it may differ from what the insurance carrier will ultimately pay. You, the responsible party, are responsible for any amount not paid by the insurance for any reason. You may receive a statement/invoice reflecting the balance due which will be due immediately upon receipt. In addition, maximum service charges will be charged in the event that a payment made via check, electronic authorization or debit is returned.
In the event that you choose to discontinue treatment, including but not limited to, partials, dentures, crowns, bridgework and surgical preparatory work, you will remain responsible for paying all lab related costs.
All accounts not paid upon becoming due will result in you, the responsible party, being sent to collections, which in turn results in being reported to credit bureaus, collection agency fees, reasonable attorney fees, and court costs.
In the event that your records are needed and are not sent directly to another provider, there will be a charge of $15.00 for copies of x-rays, and if treatment information is needed there will be an additional $5.00 fee, or the maximum amount allowed by law or your insurance carrier. Fees are subject to change without notice.
MISSED APPOINTMENTS
Appointment times are reserved especially for you and for whom you are financially responsible for. If you are more than 15 minutes late, for any reason, you may be requested to reschedule your reservation and be charged the ***$75.00*** (based on insurance guidelines) missed appointment fee. This fee will also be charged if you fail to show to an appointment. Skylight Dental Care **requires at least 24 hours notice** if you need to cancel or reschedule your reserved time. Due to high request volume, any failed afternoon appointments may result in loss of privilege to schedule at these times.
I have thoroughly read, understand and agree to the above terms and conditions.

___________________________________ ____

Printed Name Patient Name (if guardian is signing)

____________________________________ ____________________

Signature of Patient (or authorized guardian) Date

____
Relationship to patient

Patient Registration Form:

Patient Information/Información del Paciente:

Date/Fecha: ____________________

____ (Last Name, First Name and Middle Initial / Apellido, Nombre)

____________________ (Date of Birth/ Fecha de Nacimiento)

_______-_______-_______ SS# / Numero de Seguro Social

______________________________ E-Mail / Correo Electrónico

Address/ Dirección _______________ City/Ciudad _______________ State/Estado _______________ Zip/Código Postal _______________

______________________________ Phone Number / Numero de Teléfono

______________________________ Alternate Phone Number/ Numero Secundario

__________ EXT.

Emergency Contact:

____ (Last, First and Middle Initial / Apellido, Nombre)

____________________ Phone Number / Numero de Teléfono

Responsible Party Information (If other than the patient) / Información de la Persona Responsable por el Paciente (Solo necesario llenar esta sección si usted no es el paciente) :

____ (Last Name, First Name and Middle Initial / Apellido, Nombre)

____________________ (Date of Birth/ Fecha de Nacimiento)

______________________________ Relationship to Patient / Relación con el Paciente

______________________________ E-Mail / Correo Electrónico

Address/ Dirección _______________ City/Ciudad _______________ State/Estado _______________ Zip/Código Postal _______________

______________________________ Phone Number / Numero de Teléfono

______________________________ Alternate Phone Number/ Numero Secundario

__________ EXT.

Insurance Information/ Información de Seguro:

☐ Self Pay/ No tengo Seguro

☐ Medicaid/Seguro dental proveído por el Gobierno

☐ PPO Insurance/ Seguro PPO

______________________________ Insurance Company / Nombre de Seguro Dental

______________________________ Subscriber Id/ Numero de Miembro

_______-_______-_______ SS# / Numero de Seguro Social

______________________________ Employer / Empleador

______________________________ Group # / Numero de Group

______________________________ Ins. Phone # / Teléfono de Seguro

____ (Subscriber Last, First and Middle Initial / Apellido y Nombre del encargado del Seguro)

______________________________ (Subscriber Date of Birth/ Fecha de Nacimiento del encargado de Seguro)

Privacy HIPAA Consent Form

I ______________________________, give ____________________________ permission

(Name of Patient) (Name of Authorized Individual)

to discuss any appointments and/or treatment related to my care as well as pick up any documents/cases on my behalf. This consent will be valid as of __________________ unless revoked in writing to Skylight Dental Care, or myself. (Date)

____________________________ ____________________
____

Signature Date

____

Printed Name

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

- [ ] Pregnant/Trying to get pregnant?
- [ ] Nursing?
- [ ] Taking oral contraceptives?

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics
- [ ] NO ALLERGIES

Question	Answer	
Do you use controlled substances?	Yes No	If yes
Other?	[ ]	If yes

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No	Autism	Yes No	ADD/ADHD	Yes No		

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X______________________________ Date:___________

Skylight Dental Care PLLC

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Revised as of July 31, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer for Skylight Dental Care, Emilly Trice at 117 N. Oakwood Avenue or call: 813-530-0991.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing Skylight Dental Care's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). Skylight Dental Care is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that Skylight Dental Care maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by Skylight Dental Care and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits Skylight Dental Care to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. Skylight Dental Care will comply with whichever law is stricter.

1. **Treatment**: SKYLIGHT DENTAL CARE may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, SKYLIGHT DENTAL CARE may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, SKYLIGHT DENTAL CARE may contact you to remind you of a scheduled appointment.

2. **Payment**: SKYLIGHT DENTAL CARE may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, SKYLIGHT DENTAL CARE may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, SKYLIGHT DENTAL CARE may disclose to a third party payer or grant funding service, as necessary, the type of services you received to reimbursement for your treatment.

3. **Health Care Operations**: SKYLIGHT DENTAL CARE may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of SKYLIGHT DENTAL CARE's health care professionals, business planning and development, business management and general administrative activities. For example, SKYLIGHT DENTAL CARE may disclose your PHI to accreditation agencies reviewing the types of services provided.

4. **Required by Law**: SKYLIGHT DENTAL CARE may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. **Public Health**: SKYLIGHT DENTAL CARE may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. **Abuse, Neglect or Domestic Violence**: SKYLIGHT DENTAL CARE may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and SKYLIGHT DENTAL CARE believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. **Health Oversight Activities**: SKYLIGHT DENTAL CARE may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; liSkylight Dental Caresure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

8. **Judicial and Administrative Proceedings**: SKYLIGHT DENTAL CARE may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. **Law Enforcement Purposes**: SKYLIGHT DENTAL CARE may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, SKYLIGHT DENTAL CARE is not able to obtain your consent; (d) if the information relates to a death SKYLIGHT DENTAL CARE believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of SKYLIGHT DENTAL CARE ; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. **Coroners, Medical Examiners and Funeral Directors**: SKYLIGHT DENTAL CARE may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. SKYLIGHT DENTAL CARE may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. **Research**: SKYLIGHT DENTAL CARE may use or disclose your PHI for research purposes, provided than an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. **Serious Threat to Health or Safety**: SKYLIGHT DENTAL CARE may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. **Specialized Government Functions**: SKYLIGHT DENTAL CARE may also disclose your PHI, (a) If you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation**: SKYLIGHT DENTAL CARE may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, SKYLIGHT DENTAL CARE may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) SKYLIGHT DENTAL CARE has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure**: You have the right to request that SKYLIGHT DENTAL CARE restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that SKYLIGHT DENTAL CARE restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, SKYLIGHT DENTAL CARE is not obligated to agree to any restriction that you request. If SKYLIGHT DENTAL CARE agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). SKYLIGHT DENTAL CARE will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not SKYLIGHT DENTAL CARE will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Authorization Required**: Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization. In addition, disclosure of psychotherapy notes is prohibited without your authorization, except as allowed by law.

19. **Fundraising**: SKYLIGHT DENTAL CARE may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications**: You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from SKYLIGHT DENTAL CARE in alternative means or at alternative locations. SKYLIGHT DENTAL CARE will accommodate all reasonable requests, but certain conditions may be imposed.

To request that SKYLIGHT DENTAL CARE make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you with to receive such communications. SKYLIGHT DENTAL CARE will not ask why you are making such a request.

21. **Access to PHI**: You have the right to inspect and obtain a copy of your PHI maintained by SKYLIGHT DENTAL CARE. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that SKYLIGHT DENTAL CARE is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, SKYLIGHT DENTAL CARE may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits SKYLIGHT DENTAL CARE to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a liSkylight Dental Caresed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. SKYLIGHT DENTAL CARE will comply with the decision of the reviewing health care professional.

22. **Amending PHI**: You have the right to request that SKYLIGHT DENTAL CARE amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. SKYLIGHT DENTAL CARE may deny your request if it does not contain a reason that supports the requested amendment. Additionally, SKYLIGHT DENTAL CARE may deny your request to have your PHI amended if it determines that: 1) the information was not created by SKYLIGHT DENTAL CARE and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach**: SKYLIGHT DENTAL CARE will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI**: You have the right to request a listing of certain disclosure of your PHI made by SKYLIGHT DENTAL CARE during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. SKYLIGHT DENTAL CARE will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. SKYLIGHT DENTAL

CARE will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice**: You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26. If you believe that your privacy rights have been violated, you may file a complaint with SKYLIGHT DENTAL CARE or with the Secretary of Health and Human Services. To file a complaint with SKYLIGHT DENTAL CARE, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. SKYLIGHT DENTAL CARE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.