KOCH
AESTHETIC
DENTISTRY

Welcome to our family of fine patients and thank you for selecting us as your personal dental care team. We will always strive to make your relationship with us as pleasant and rewarding as possible.

Your visit with us will consist of meeting our team, taking a tour of our office, and a comprehensive exam with Dr. Koch.

Responsible, professional dental care relies on providing a firm foundation on which we can base recommendations for your dental health. Therefore, your next visit with us may consist of a thorough examination and any necessary x-rays that will aid us in giving you the finest dental care possible. Feel assured that we will only recommend the minimal x-rays needed and that we will show you how to control your dental destiny. Because our office employs the use of digital (computerized) x-rays exclusively, the amount of radiation is reduced as much as 90% compared to traditional x-ray systems.

Enclosed you will find a health record form that we would like you to complete and bring to our office on the day of your visit. Your overall health can significantly affect your oral health and a thorough health record allows us to make a more thorough diagnosis.
Our goal is for you to be happy with our office and completely satisfied in feeling that we are unconditionally committed to making you feel special. A misunderstanding can be an obstacle to forming this relationship and we ask that if at any time you have a question or are unhappy about any treatment, fee, or service, please discuss it with us promptly and openly.

A long term, mutually satisfying relationship, which gives you the ability to maintain optimum dental health, is what we want for you, your family, and for our own satisfaction. Thank you again for selecting us and we are looking forward to seeing you.

Sincerely,

J. Paul Koch, D.M.D.
Enclosures

KOCH AESTHETIC DENTISTRY

WELCOME

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

ABOUT YOU

Today's date _____
Mr./Mrs./Ms./Miss Name: _____
I like to be called: _____

Home address:_____ City:_____
Zip:_____ Social Security Number:_____
Employer:____ _____Occupation: _____
Student:_____ School Attending:_____
Date of birth: _____Who may we thank for referring you? _____
Marital status: □ Single □ Married □ Divorced □ Widowed
Spouse's name:_____
Do you have dental insurance?_____ Parent/guardian name if patient is a minor:_____
_____ Employer:_____ Date of Birth: _____

Special interests or hobbies:
_____

CONTACT INFORMATION

Home phone:_____
Work phone: _____
Cell phone: _____
E-mail address_____
When is the best time to call you?_____ and Where?_____
In case of emergency, is there someone we can call?
Name:_____ Phone Number:_____

KOCH AESTHETIC DENTISTRY

MEDICAL HISTORY

Name of personal physician:_____ Phone number:_____
Last visit with physician:_____ Current Health: □Excellent □Good □Fair □Poor
Do you smoke or use chewing tobacco? □Yes □No If Yes, How Much Per Day?_____
Do you consume alcohol? □Yes □No If yes, in what quantities?_____
Are you currently taking prescription medications? □Yes □No, if yes, please list below
Name of medication Purpose

_____
_____
_____

For Women: Are you pregnant? □ Yes □ No, if Yes, how many months? _____
Do you plan on becoming pregnant in the near future and when? _____
Have you had any serious medical problems within the past 5 years? □Yes □No, if yes, please explain:_____

Please circle if you have, or have ever had, or been treated for any of the following diseases or medical problems?

Abnormal bleeding	Emphysema	Mitral Valve Prolapse
AIDS/HIV	Epilepsy	Nervous Disorder
Allergies (Seasonal)	Excessive Bleeding	Pacemaker
Anemia	Facial/Head Injuries	Prosthetic Valves
Arthritis	Fainting	Psychiatric Problems
Artificial Heart Valve	Glaucoma	Radiation
Asthma	Headaches	Respiratory Problems
Blood Disorder	Heart Conditions	Rheumatic Fever
Cancer _____	Heart murmur	Rheumatism
Chemotherapy	Hepatitis/Jaundice	Scarlet Fever
Depression	High Blood pressure	Seizures
Diabetes	Jaundice	Stomach Problems
Digestive Problems	Joint Implants	Stroke
Dizziness	Kidney problems	Thyroid Disease
Drug/Alcohol abuse	Liver Disease	Tuberculosis
Eating Disorders	Low Blood Pressure	Ulcers
		Venereal Disease

Have you been treated for any other illnesses not listed above? □Yes □No, if yes, please explain:_____
Do you need to be pre-medicated before dental treatment? □Yes □No □Don't know

Are you allergic to any of the following? Y N Penicillin Y N Aspirin Y N E-mycin Y N Codeine Y N Dental Anesthetic Y N Latex
Are you allergic to any other medications? □Yes □No, if yes, please explain:_____
Have you recently or are you currently taking Fosemax, Boniva, Actonel, Pamidronate IV or Zolendronate IV? □Yes □No

DENTAL HISTORY

Are you currently in pain or discomfort with your teeth or gums? □Yes □No, if yes please explain:_____
Previous dentist's name?_____
Reason for leaving? _____
The date of your last dental visit: _____ Date of last x-rays_____
Date of last oral cancer screening: _____ Date of last gum charting:_____
Do you have or have you had any of the following: Braces? _____Gum Treatments?_____
How often do you brush your teeth?_____ Floss your teeth?_____
Do your gums bleed when you brush?□ Yes □ No Floss? □Yes □No
Do you have swollen or irritated gums? □Yes □ No
Do you or have you ever experienced bad breath? □Yes □ No
Have you ever experienced pain in your jaw joint □Yes □ No
Do you grind or clench your teeth? □ Yes □No
Do you notice your jaw clicking or popping? □Yes □No
Have you ever been treated for TMJ symptoms? □ Yes □ No, if yes please explain:
_____
Do you notice discomfort in face, head, neck or jaw? □Yes □ No
Are your teeth sensitive to sweets, hot or cold? □Yes □ No Where?_____
Are any of your teeth loose? □Yes □No Are any of your teeth tipped or shifting? □Yes □ No
Have you had any problems with previous dental treatment? □Yes □No If so, please explain_____
Do you need nitrous, oral /IV sedation for dental visits? □Yes □ No

"If I could change my smile, I would": (circle all that apply)

-Safely make my teeth whiter
-Make my teeth straighter
-Close spaces
-Replace metal fillings with tooth colored restorations
-Repair chipped teeth
-Replace missing teeth
-Replace old crowns/veneers that don't match
-Have a smile makeover
-Make sure my mouth is healthy

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

To avoid any misunderstandings regarding your dental insurance, we wish our patients to know that **all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees.** We do not render services on the basis that the insurance companies will pay our fees unless a pre-determination of benefits has been established. We will assist you in filing all insurance forms. **Payment is due when services are rendered unless other arrangements have been made.**

I hereby authorize Dr. Koch to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Koch to make a thorough diagnosis of my dental needs. I also authorize Dr. Koch to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon. I give Dr. Koch or his team permission to use any photos he may take to be used for lecturing or educational purposes.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. I understand that responsibility for payment for dental services provided in this office for my dependents or me is mine, due and payable at the time services are rendered.

Signature of patient or responsible party_____

Date _____

GUEST FINANCIAL ALLIANCE

Welcome to our office. We are honored that you have chosen us as your dental healthcare provider. We are committed to providing you with the best possible care! If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment alliance. We will always clarify financial arrangements prior to treatment.

1. PAYMENT IS DUE AT TIME SERVICES ARE RENEDERED unless other payment arrangements have been approved, in advance, by our staff. We accept payment for services in cash, check, American Express, Mastercard or Visa. _____ (please initial).
2. If you have dental insurance we will be happy to file and have your insurance company reimburse you.
3. For extensive treatment we offer an accounting courtesy for treatment over $5000 and is paid in full prior to the service.
4. As a courtesy to our patients, we have extended financing available through CareCredit and/or Healthcare Finance. These resources are available to support you in having optimal treatment when you need it. Please check if you are interested in extended financing. Yes____ No____
5. Fees quoted are accepted for 90 days. In the event that clinical conditions warrant a different treatment, you will be notified of changes in fees prior to proceeding with the procedure.
6. Balances older than 60 days will be subject to interest charges of 1.5% per month, or 18% annually.
7. A $32.00 NSF fee will be charged for all returned checks.
8. In the event that payment is not made for services after a reasonable period of time, our attorney will be advised and formal action to collect will be initiated. You will be responsible for any attorney's fees and/or collection charges incurred.
9. Broken appointments and appointments canceled with less than 24 hours advance notice will be subject to a broken appointment or last minute cancellation fee.

Insurance

The process of utilization and quality of insurance has changed much over the years. We will do our best to help you understand and utilize your benefits. The amount of coverage your insurance provides is strictly a function of the policy selected by you and your employer.

Note: Your insurance is a contract between you, your employer and the insurance carrier. We are not a party to that contract. If you have a problem with your insurance coverage, we ask that you speak directly to your insurance company. Your charges in our office are your responsibility from the date the services are rendered. We do not base your diagnosed treatment on your insurance coverage. We base it on your need and desires. We take pride in the quality care we offer our patients and make every effort to have your dental visits with us be as comfortable as possible.

Thank you for reviewing our financial policy. We make every effort to explain your costs to you and to avoid misunderstandings so that we can focus on your dental health. If you have any questions please ask. We are here to serve you.

I have read, understand and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Signature_____ Date _____

Witness_____Date_____

KOCH AESTHETIC DENTISTRY

LEVELS OF CARE

We understand that choosing a new dentist and dental health team can be a challenge, leaving you feeling somewhat uncertain. Let us welcome you and share some insights about what we do for our patients. The philosophy guiding our practice is as follows:

"Our purpose is to help people achieve the highest level of well-being appropriate for them and, in so doing, to enhance the quality of their lives."

In other words, we help you be or become as healthy as you choose. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. Your first choice in this regard is how you would like to begin with us. There are five levels on which people may choose to be seen in our practice. Please initial the level of care you feel most appropriate for you at this time.

____ Level 1 URGENT CARE: People in crisis or with an emergency problem such as pain, swelling, or bleeding that need our immediate help are at this level. We see urgencies immediately, whenever possible.

____ Level 2 REMEDIAL CARE: People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally people at this level expect a limited type of examination, focusing on obvious problems. They usually want to correct immediate problems with as little effort and cost as possible.

____ Level 3 SELF-CARE: Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However, they usually choose repair solutions that are short range in nature.

____ Level 4 COMPLETE DENTISTRY: Patients at this level are similar to people described in level 3. They choose to have a thorough examination. However, they decide on a MASTER PLAN to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all dental treatment provided to be completed in the most lasting fashion possible.

____ Level 5 LOOK YOUR BEST: People in this group are in Level 4 as far as dental health is concerned, but also want to look their best at all times. They know that their smile is the first thing others notice about them and want to put their best foot forward.

We hope these levels of care make sense to you. It is not uncommon for people to begin at one level and progress to another over time. We are here to help you discover and decide at what level you are most comfortable. Thank you for the opportunity to serve you and provide you with the best dentistry appropriate for you.

Sign_____ Date_____

KOCH AESTHETIC DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

KOCH AESTHETIC DENTISTRY

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 RESPONSIBILITIES

We at Koch Aesthetic Dentistry understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 04/14/03, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 state or federal law, including with the Dept. of Health and Human Services if it wants to see that we are complying with federal privacy 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.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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, mailing 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 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 at 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.

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 by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Jenny Walker
Telephone: (205) 933-0323
E-mail: jwalker@kochaesthetics.com
Address: 2311 Highland Avenue South, Suite 323, Birmingham, AL 35205