Dr. LAMPEE™

Patient Information

Name_____ Preferred Name_____

Address_____ Unit_____

City_____ State_____ ZIP_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____ Date of Birth (mm/dd/yy)_____

Why are you here today?_____

How Did you Hear About us?

- ☐ TV Commercial
- ☐ Good Day Oregon
- ☐ AMNW
- ☐ Social Media
- ☐ Internet
- ☐ Radio
- ☐ Drive By / Sign Outside
- ☐ Youtube/Streaming
- ☐ Word of Mouth
  Who: _____
- ☐ Other:_____

Emergency Contact

Name_____

Home Phone_____ Work Phone_____ Cell Phone_____

Relationship to Patient: Parent / Guardian / Spouse / Other:_____

Phone | 503-646-2273
Fax | 503-277-1535

www.drlampee.com

14455 S.W. Allen Boulevard, Suite 103
Beaverton, Oregon 97005

Dr. LAMPEE™
IMPLANTS | VENEERS | LASER

Patient Medical History

Name_____ DOB_____

Physician's Name_____

☐ Check if you are under medical treatment now.

If checked, what for?_____

☐ Check if you are or have ever been hospitalized for any surgical procedure or serious illness.

☐ Check if you are taking any medication(s) including non-prescription.

If checked, what medication(s) or supplements) are you taking?_____

_____

☐ Check if you use tobacco / cannabis products. If yes, what type & how often?_____

☐ Check if you use alcohol. If yes, what type & how often?_____

☐ Check if you have a history of drug or alcohol abuse. If checked please specify?_____

☐ Check if you have taken or are currently taking bisphosphonates.

☐ Check if you have had bariatric surgery. If checked, please specify type & date _____

Are you allergic to or have you had any reaction to the following? Check all that apply.

☐ Topical Anesthetics
☐ Local Anesthetics
☐ Latex
☐ Aspirin
☐ Tylenol
☐ Ibuprofen (Advil)
☐ Prescription Pain Medications
☐ Sulfa Drugs
☐ Penicillin
☐ Sedatives

Other:_____

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Patient Medical History
continued

Do you or have you had any of the following? Check all that apply.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder_____
- ☐ Blood Pressure - High
- ☐ Blood Pressure - Low
- ☐ Blood Thinners
- ☐ Cancer
  - Area_____
  - Year_____
- ☐ Chest Pains
- ☐ Cold Sores
- ☐ Convulsions
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type I or II. Last A1c_____
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Frequently Tired
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type A / B / C
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mental Illness_____
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation
  - Area_____
  - Year_____
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Weight Loss
- ☐ Other:_____

Women Only. Check if you are:

- ☐ Pregnant
- ☐ Nursing
- ☐ Taking birth control pills

Patient Consent Agreement

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information may be dangerous to my health. I hereby authorize and request the performance of dental services for myself and/or for:

Name_____

I authorize and give consent to perform dental services agreed upon between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated.

Patient or Guardian Signature_____ Date_____

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Policy Acknowledgment

We are committed to providing you with the best possible dental care. In order to achieve this we need your assistance and your understanding of our payment policies.

Financial Information

- We accept the following major credit/debit cards: Visa, Mastercard, Discover, and American Express.
- For those who desire a payment plan, we are partnered with Care Credit, Lending Club, and Proceed Financing. These payment plans are based on your approved credit. There are no application fees. These arrangements must be made prior to treatment.
- Payment for treatment is due at time of service. If you are requiring sedation, payment is due upon scheduling the appointment.
- We do not contract or bill insurance.
- Balances over 90 days will be assigned to a collection agency and will incur a $50.00 collection fee. Any checks returned to our office for non-sufficient funds will be subject to a fee of $25.00.

Usual and Customary Rates

We charge what is usual and customary for our area. Please be aware that some of the services we provide may not be covered services by your dental plan. You are responsible for payment regardless of your insurance company's exclusions and fee schedules. Your insurance policy is a contract between you and that insurance company. We are not able to negotiate with your insurance company on your behalf.

I have read the Policy Acknowledgment and understand that as a patient, or responsible party, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of this office as stated above.

Patient Signature or Responsible Party _____ Date _____

Missed Appointment Policy

We require two business days' notice to reschedule an appointment. Our business days are Monday–Thursday.

- There is no fee for your first missed appointment. We understand that life happens.
- There is a $50 fee for your second missed appointment.
- There is a $100 fee for your third missed appointment.
- Additional missed appointments will result in us not being to see you as a patient.
- If a sedation appointment or appointment lasting two or more hours is missed or rescheduled with less than two business days' notice, 10% of your appointment cost is non-refundable

Patient Signature or Responsible Party _____ Date _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Notice of Privacy Practices.

The Notice of Privacy Practices explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Notice of Privacy Practices, please feel free to direct these to our Privacy/Security Officer at any time. The name and contact number of the Privacy/Security Officer is listed on your copy of the Notice of Privacy Practices

Patient Name:_____ Date of Birth:_____

Patient to complete this section

I have received a copy of the Notice of Privacy Practices for this organization on today's date.

Signed:_____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Notice of Privacy Practices was provided to

Patient Name:_____ On _____

The patient was unable to acknowledge receipt of the Notice of Privacy Practices for the following reason:

_____
_____
_____

Signed:_____

File this form in the patient's chart

Dr. LAMPEE

Notice of Privacy Practices

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.

Our organization is committed to providing you with medical care that meets your needs. An important aspect of our service commitment to you is the protection and security of the protected health information that we obtain about you. We have always safeguarded your health information and our written privacy policy gives us an opportunity to share with you our policies that protect your health information.

We are required by law to provide you with this notice. It will describe to you what protected health information we collect about you and how that information might be used.

The Type Of Protected Health Information That We May Obtain About You:

Demographic Information: Including your name, address, date of birth, phone number(s), name of your employer, your spouse or other family members, and emergency contact.

Insurance Information: including your insurance carrier, the name of the insured person, insurance identification numbers, and benefits and eligibility information.

Health Information: Including your health history, past illnesses or injuries, family medical history, your social activities including use of tobacco, alcohol, or drugs, family life and living situation, your current and/or ongoing health problems, including medications, allergies, advised treatment and outcomes of that treatment.

Payment Information: Including your insurance carrier, your record of charges, adjustments, and payments to our organization.

How We May Use and Disclose Protected Health Information About You:

Section 1:
We are not obligated to have your consent when using or disclosing protected health information for the following purposes:

A. **For Treatment:** We may use and disclose your health information to provide, coordinate or manage your health care and any related services. We may disclose information about you to doctors, dentists, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example:
- ◊ *If we schedule a test, therapy or surgery for you, we must provide information about you in order to complete the scheduling. This includes your name, demographic and insurance information and the reason for the test.*
- ◊ *Your doctor may share your medical information with another doctor who is also involved in your care so that both may have all the information to make the best treatment decisions for you.*
- ◊ *We may share information with a pharmacy so that they can fill or refill a prescription for you.*
- ◊ *We may share information about you with another provider who is on call in the absence of your provider.*

B. **For Payment:** We may use and disclose your information to obtain payment for services you receive. If you pay in full for service out of pocket you have the right to restrict your information being given to any health plan.

For example:
- ◊ *We may use or disclose your information to determine eligibility for insurance or benefits.*
- ◊ *We may use the name of your insurance carrier and your identification numbers in order to file a claim for you.*
- ◊ *We may disclose your information about your conditions or reasons for seeking care and the care that is provided to your insurance carrier so that they may process and pay your claim.*
- ◊ *We may disclose information about your conditions to your insurance carrier to seek approval as necessary for recommended tests and treatment.*
- ◊ *We may provide information about your services to a health care clearinghouse so that they may distribute a claim to your insurance carrier on our behalf.*

- ◊ *If we refer you to another facility or provider we may provide them with your insurance information to expedite your registration and assure that they are participants in your insurance plan.*

C. **For Health Care Operations:** We may use or disclose protected health information about you in order to evaluate our care for you or to meet a business need of the organization. These activities include quality assessment activities, employee review activities, training students, compliance audits by your insurance carrier, and conducting or arranging for other business activities.

For example:
- ◊ *We may use information about you to evaluate the performance of our staff in caring for you.*
- ◊ *We may use your information to evaluate our efficiency.*
- ◊ *We may use your information to evaluate and respond to a patient complaint.*
- ◊ *We may share your health information with students or residents who are learning to care for patients.*

We may also use or disclose protected health information to our Business Associates in the performance of health care operations. A Business Associate is an entity or person engaged by this organization to perform a business activity on behalf of the organization. Our Business Associates are obligated by contract to protect health information they receive or generate about you.

For example:
- ◊ *We may provide information to our transcription service so that they can produce a written copy of your encounter in our office.*
- ◊ *We may provide information to our accountant in order to prepare our organization's financial reports.*
- ◊ *We may share information with qualified consultants in order for them to provide business management advice.*

D. **Other Contact Situations:**
- ◊ We may use your information to call and remind you of an appointment in our office.
- ◊ We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- ◊ We may tell you about health-related products or services that may be of interest to you.
- ◊ We may use your information for marketing, and fund raising you do have the right to opt out of the marketing and fund raising information.

E. **Special Situations:**
Emergencies: We may use or disclose protected health information in the case of a medical emergency.

Required by Law: We may use or disclose your protected health information if the disclosure is required by law.

Public Health: We may disclose protected health information about you for public health activities. These activities generally include the following:
- ◊ To prevent or control disease, injury or disability
- ◊ To report births or deaths
- ◊ To report child abuse or neglect
- ◊ To report reactions to medications or problems with products
- ◊ To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- ◊ To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight: We may disclose protected health information to health oversight agencies that oversee our activities. These activities may include audits, investigations and inspections and are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits or Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. Subject to legal requirements, we may also disclose medical information about you in response to a subpoena.

Law Enforcement: We may disclose protected health information, so long as all applicable legal requirements are met, for law enforcement purposes.

Coroners, Medical Directors and Funeral Directors: We may disclose protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release information about patients to funeral directors as necessary to carry out their duties.

Workers Compensation: We may disclose medical information about you for programs that provide benefits for work-related injuries or illness.

Military Activities, National Security and Intelligence Activities: If you are a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to disclose protected health information about you. We may also disclose information about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donation: If you are an organ or tissue donor, we may disclose protected health information to organizations that handle organ or tissue procurement when necessary to facilitate organ or tissue donation or transplantation.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. The release would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use or disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Information that is not personally identifiable: We may use or disclose information about you in a way that does not personally identify you.

Section 2:
Protected Health Information Use and Disclosure That Requires an Opportunity for You to Agree or Object

Family and Friends: We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Section 3:
Protected Health Information That Cannot Be Disclosed Without Your Specific Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may revoke this authorization by notifying us in writing at any time.

<u>Your Rights as a Patient:</u>

- **You have the right to inspect and copy your protected health information.**
  You may inspect and obtain a copy of your protected health information maintained in our office. We may charge you for the cost of copying, mailing or associated supplies.

  Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. Certain documents pertaining to laboratory services are also exempt under federal law.

  You have the right to an electronic copy of your records however this office does not have electronic records. However we will copy your paper chart if requested in writing.

  You have the right to request your records be sent via e-mail with the understanding that we will try and verify your email before sending. E-mail is not always secure and you are acknowledging this fact. This request must be done in writing.

  Under certain circumstances, we may not grant your request. If we deny your request, then you may appeal our decision.

  We require that requests to access your protected health information be made in writing. You can arrange to do this through our Privacy/Security Officer.

- **You have the right to request a restriction of your protected health information.**
  You may ask us not to disclose your protected health information for treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to friends and/or family members involved in your care.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency care.

  In order to request a restriction, you must do so in writing. The request must specifically state what information is restricted and to whom the restriction applies.

You may request a restriction form from our Privacy/Security Officer.

◊ **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**
You may request that we communicate with you in a certain way or at a specific location. We will attempt to accommodate all reasonable requests.

Please contact our Privacy/Security Officer to make this request in writing. Your request must specify where or how the communication is to be directed.

◊ **You have the right to request that we amend your protected health information.**
If you believe that protected health information we have about you is incorrect or incomplete, you may request an amendment to this information.

We may not grant your request if we determine that the protected health information that is the subject of your request:

- ◊ was not created by our organization
- ◊ is not a part of your medical or billing records
- ◊ is information that you are not permitted to inspect or copy
- ◊ is already a complete and accurate record

Amendment requests must be made in writing and must include a reason for requesting the amendment. If you wish to amend your record, you may contact our Privacy/Security Officer for a form.

◊ **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**
You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than you, except for disclosures:

- ◊ to carry out treatment, payment and health care operations as described above
- ◊ to persons involved in your care or for other notification purposes as provided by law
- ◊ for national security or intelligence purposes as provided by law
- ◊ to correctional institutions or law enforcement officials as provided by law
- ◊ that occurred prior to April 14, 2003

You are allowed one free disclosure per each twelve-month period. If you wish additional disclosures within that twelve-month period, we may charge you the cost of providing the disclosure list.

Your request for a disclosure accounting must be made in writing. Please contact our Privacy/Security Officer to obtain a form.

◊ **You have the right to file a complaint.**
If you believe that your privacy rights have been violated, you have a right to file a complaint in the form of a written letter with our office and with the Secretary of Health and Human Services without fear of retaliation.

A letter of complaint filed with this office should be sent to our Privacy/Security Officer at the address listed below.

◊ **You have the right to request and receive a paper copy of this notice from our office.**

Revisions to Our Privacy Notice:

We are required to abide by the terms of this Privacy Notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. This notice is in effect as of September 23, 2015 Upon your request, we will provide you with a revised Privacy Notice. You may obtain this by calling our office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

Questions/Contact:

If you have questions about this document, or have questions about privacy or patient rights, please contact our Privacy/Security Officer.

Privacy Officer Name: Wanda Sampson

Address: 14455 SW Allen Blvd Ste. 193
Beaverton, OR 97005

Phone Number: 503-646-2273