Tarpon Springs Dental *1779 S Pinellas Ave., Ste. 100 Tarpon Springs FL 34689 P:727-944-3288 www.tarponspringsdental.com*

PATIENT INFORMATION

_____ ☐Male ☐Female ☐Married ☐Single ☐Minor

First Name M. Last Name

ADDRESS:_____

#Street Apt.# City State Zip

SSN:_____-____-_____DATE OF BIRTH:_____RESPONSIBLE PARTY: ☐Self ☐Spouse ☐Guardian ☐Parent

(MM/DD/YYYY)

STATE DRIVER'S LICENCE#:_____

CONTACT INFO:

_____

☐***Home Phone*** ☐***Cell Phone*** ☐***Work Phone*** ☐***e-Mail Address***

EMERGENCY CONTACT: Name:_____ Phone:_____ Relationship:_____

METHOD OF PAYMENT (please select as many as applicable):

☐Payment in full at each appointment (cash, check)

☐Credit card: VISA, MC, AMEX, DISC - #:_____Exp. Date:_____ CCV: _____

☐HSA/FSA: #:_____ Exp. Date: _____ CCV:_____

☐Third Party Financing – Would you like to apply for? : ☐CareCredit and/or ☐Springstone Financing

INSURANCE INFORMATION (We will work with your insurance to maximize your dental benefit. **IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY**)

PRIMARY INSURED:_____ DATE OF BIRTH:_____

First M. LAST MM/DD/YYYY

ADDRESS:_____ RELATIONSHIP TO PATIENT:_____

#Street Apt.# City State Zip

CONTACT INFO:_____ SSN: _____-_____-_____

Home Phone Cell Work E-mail

EMPLOYER:_____ DENTAL INS. CO._____

SUBSCRIBER #:_____ GROUP #:_____

AUTHORIZATION: I authorize payment directly to XHOANA GJELAJ DMD, (Tarpon Springs Dental) of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and insurance may not cover all or part of the treatment administered by the dentist and agree to pay all costs of such treatment in a timely manner in accordance with the financial policies of XHOANA GJELAJ DMD, (Tarpon Springs Dental). I also understand that appropriate service and billing charges (at least 5% of balance and at least $50 per billing cycle) will be applied to my account for past due balances. I authorize Xhoana Gjelaj DMD (Tarpon Springs Dental) to charge my credit card for any balances incurred on my account in accordance with provisions in my insurance plan and/or written financial policy of the office. I authorize XHOANA GJELAJ DMD to use my records for clinical and illustrative purpose within the context of the dental office. I hereby authorize XHOANA GJELAJ DMD, (Tarpon Springs Dental) to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information submitted on this form and medical/dental histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method including electronic transfer.

X_____ DATE:_____ _____

Patient or responsible party MM/DD/YYYY

Med and Health Hx(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

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, drugs, or supplements?	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?
- Test Item

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?		If yes

Dental History

Are you in Pain?	Yes No	If yes

Are you experiencing any of the following?

Sensitive to Biting or CHewing	Yes No	Bleeding in the Gums	Yes No	Popping in the Jaw	Yes No

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

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						

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

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:_____

Comments:

WRITTEN FINANCIAL POLICY

Thank you for choosing Xhoana Gjelaj DMD, (Tarpon Springs Dental). Our mission is to provide a superior dental experience through a comfortable setting and friendly staff while achieving high quality clinical results. An important part of our mission is making the cost of optimal care for our patients as easy and manageable as possible. Towards this end we offer several payment options:

- Cash
- Check*
- Credit card (AMEX, Visa, MasterCard, Discover)
- No-interest or low interest third party financing (CareCredit and Springstone Financial)**
- In-house financing for Treatment Plans costing over $5000***

Please note:

- **Payment is required prior to completion of treatment**. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. Fees for work already performed will not be refunded and all discounts given will be automatically rescinded. In case of 3rd party financing your refund maybe affected by administrative fees and interest charges.
- For patients with dental benefits, we will gladly work with you to maximize your dental benefits and even file claims with your dental benefit provider. However, **if we do not receive payment from your insurance carrier within 30 days you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. You are responsible for the full treatment fee, not just your co-pay. We ask that you submit a valid credit card on file if you would like us to file dental benefit claims on your behalf to your dental benefit company.** We will charge your credit card on file after the first 45 days insurance hasn't paid.
- **A fee of $35.00 is charged to patients who miss or cancel an appointment without 24 hour notice. A fee of $35 is charged for every 30 days a balance is overdue and an additional $50 for every 60 days a balance is overdue.**
- For treatment plans costing $5000 and over we accept payments in thirds. Payment must be completed before treatment is finished and before we take final impressions. A 30% deposit is required to schedule treatment. The total cost of the treatment must be paid before treatment is completed or before we take final impressions (for restorative work)
- Lab fees or Third-party Financing fees are non-refundable
- For IV Sedation treatment, payment in full must be made prior to scheduling treatment
- A deposit maybe required to schedule appointments. Deposit may not be refunded if the appointment is not honored or canceled within 24 hours before.
- **This policy is subject to change without notice.**

If you have any questions about your treatment plan and its cost please feel free to ask us.

_____ _____

Patient Name (Please Print) Date

_____

Patient, Parent or Guardian Signature

*A $35.00 fee and additional finance/late/billing charges will apply for each returned check.

**Subject to credit approval. 0% interest valid for promotional period only. No annual fees or penalties for pre-payment. See brochure for more info.

***As alternative to 3rd party financing for established patients only. Financial Agreement must be signed and a major Credit Card has to be on file for automatic monthly payments. Non-refundable deposit will be required to schedule treatment

DENTAL BENEFIT NOTIFICATION

Dr Xhoana Gjelaj DMD prides herself on her exceptional, comprehensive, cutting edge dental care. In the past months, many Dental Insurance Benefit providers (PPO Insurance companies) have made it extremely difficult for us to offer that level of treatment to our patients and their customers due to their unwillingness or inability to approve many advanced and beneficial forms of treatment.

We are committed to offering the same excellent dental care to each and every patient regardless of their method of payment or insurance company. Our commitment is to you, the patient, and we do not want anything to interfere with that valuable doctor-patient relationship.

In order to preserve our clinical and ethical commitment to you we often have to provide treatment that is outside the confines of the contract between you and your insurance company. This means that if something is denied or not covered, it would be your responsibility to satisfy your balance up to your quoted treatment fee.

Our contract with your insurance company requires proper notification of your dental benefit responsibility. By signing this agreement, you consent to the above statements. Be assured that you will always have the ability to accept or decline treatment.

We are excited and look forward to providing the very best service that the art and science of dentistry have to offer to you, your family, and your friends for years to come.
Thank you for your understanding in this delicate matter.

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

(You may refuse to sign this acknowledgment)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Xhoana Gjelaj, DMD (Tarpon Springs Dental) this _____ day of _____, 20____.
A copy of the signed and dated Acknowledgment shall be as effective as the original.

I acknowledge that I received a copy of Xhoana Gjelaj DMD Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority:

_____

If you have any questions about this form, please contact our office

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OFFICE USE ONLY

As a privacy office I attempted to obtain the patient's or representative's signature on this Acknowledgment but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign because:_____
- Other:_____

Signature of Privacy Office and Date:_____

Effective date of notice: 01/01/2015

NOTICE OF PRIVACY PRACTICES

Xhoana Gjelaj, D.M.D.
1779 S Pinellas Ave. Ste. 100, Tarpon Springs FL 34689
Phone: 727-944-3288
Fax: 727-944-3604
xgdentist@gmail.com
Office Manager: Valerie Kaczynski

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.

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

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

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

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission when other providers request your information or when unauthorized third parties request information on your behalf

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

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

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

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

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment

reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

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

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

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

COMPLAINTS

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

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.