

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Section 3

Referred By: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Eaglesoft Medical History (Update 11/08/17)

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.

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 If yes: \_\_\_\_\_
Do you use tobacco?  Yes  No If yes: \_\_\_\_\_
Have you ever been diagnosed with a sleep disorder or use a CPAP machine?  Yes  No If yes: \_\_\_\_\_

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

None  Penicillin  Codeine  Acrylic
 Metal  Latex  Sulfa Drugs  Local Anesthetics
 Aspirin

Other Allergies?  Yes  No If yes: \_\_\_\_\_

Do you use controlled substances?  Yes  No If yes: \_\_\_\_\_

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: \_\_\_\_\_

Comments:

[Empty text box for 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: \_\_\_\_\_



# HEATH MONTGOMERY, DMD

Creating Healthy And Beautiful Smiles

14 W. Valerio St., Ste. C  
Santa Barbara, CA 93101  
(805) 845-3240  
805-845-3244 (fax)

## Financial Policy

This is an agreement between Heath Montgomery, DMD, as a provider, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Heath Montgomery, DMD.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/billing charge(s), if any, and any payments or credits applied to your account during the month.

### **Payment options if you have no insurance:**

1. You may choose to pay by cash, check, or credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) the balance is due on the day of service or you may pay 50% of the total bill at the time of service and the remaining 50% at the time of delivery.
3. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
4. We do offer payment plans through 3<sup>rd</sup> party companies. Terms of repayment are determined by these companies depending on your qualifications.

### **Payment options if you have insurance:**

1. Your estimated out-of-pocket portion is due at the time of services rendered with cash, check, or credit card.
2. On treatment involving lab fees (crowns, bridges, dentures, etc.) your estimated out-of-pocket portion is due on the start or preparation date.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days of the date issued on the statement.

**Charges to Account:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**Contracted Insurance:** If we are contracted with your insurance company, we must follow our contract with them and their requirements for billing. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. **The agreement is between you and your insurance company, not us and the insurance company.**

**Non-contracted Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

**Re-billing Fee:** A re-billing fee of \$10 will be imposed on each account that is over thirty (30) days past-due. We determine your account is past-due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

**Credit History:** You give us permission to check your credit and employment history and to answer questions about your credit

experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

**Required payments:** Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

**Returned checks:** There is a fee (currently \$50) for any checks returned by the bank.

**Missed appointment fee:** Patients who do not show up on time for an appointment, or cancel with less than **48 hours notice will be charged a \$85 fee per hour or part thereof.** (For example, missed for 1.5hrs will be \$170.00.) This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Santa Barbara County, California.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Transferring of Records:** You will need to request in writing or verbally, whether you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**Workers Compensation:** We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your dental insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

**Co-signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: \_\_\_\_\_

Responsible party  
(if not the patient): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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[www.drmontgomerydental.com](http://www.drmontgomerydental.com)  
[info@drmontgomerydental.com](mailto:info@drmontgomerydental.com)

## INFORMED CONSENT FOR SERVICES

I give consent for the Dentist(s) at Heath Montgomery, D.M.D. to treat my dental needs. I understand that treatment recommended to me is only an estimate. I understand that complications during the course of treatment may change treatment based on those complications and recommendations may change as well. I understand **I may ask questions** about the complications and the changes in recommendations.

I understand that delay in completing recommended dental treatments may result in further changes to those recommendations if the condition for those recommendations worsen with time.

I authorize the Dentist(s) to choose the dental material that best suits my dental needs. I also understand that **I may ask questions** about the dental materials used in my treatment.

I authorize the Dentist(s) to choose the anesthesia that best suits my dental needs. I understand that **I may ask questions** about the anesthetic used in my treatment. I also understand that there are risks associated with the administration of anesthetic. Some of the risks include, prolonged, temporary, and on very rare occasion permanent, loss of feeling in the area where the anesthetic is administered. Also, prolonged trismus (sore muscle) around the area of administration may occur once the anesthetic has worn off.

I understand there is a **48 hour cancellation policy**. If I cancel less than 48hrs prior to my dental appointment, or do not show up, there will be a "No Show Fee" added to my account for every hour or part there of that is missed as stated in my financial agreement form I signed.

I have read the above policies and conditions. I consent to treatment in this office for myself, and anyone for whom I am legally responsible.

\_\_\_\_\_  
Signature of the Patient /Responsible party

\_\_\_\_\_  
Date



## **HIPAA 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.**

### **I. Dental Practice Covered by this Notice**

This Notice describes the privacy practices of Heath Montgomery, D.M.D. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

### **II. How to Contact Us/Our Privacy Official**

If you have any questions or would like further information about this Notice, you can contact Heath Montgomery, D.M.D.'s Privacy Official at:

Heath Montgomery, D.M.D.  
14 W Valerio St, Suite C Santa Barbara, CA 93101  
Phone: (805)-845-3240, Fax: (805)-845-3244  
info@drmontgomerydental.com

### **III. Our Promise to You and Our Legal Obligations**

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

### **IV. Last Revision Date**

This Notice was last revised on January 1, 2015.

### **V. How We May Use or Disclose Your Health Information**

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

#### **A. Common Uses and Disclosures**

- 1. Treatment.** We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.
- 2. Payment.** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.
- 3. Health Care Operations.** We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.
- 4. Appointment Reminders.** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.
- 5. Treatment Alternatives and Health-Related Benefits and Services.** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
- 6. Disclosure to Family Members and Friends.** We may disclose your health information to a family member or friend who is involved with your care or payment for your care **if you do not object or, if you are not present**, we believe it is in your best interest to do so.

**7. Disclosure to Business Associates.** We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are

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18898.1.Rev002 10.01.2013

obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

## **B. Less Common Uses and Disclosures**

**1. Disclosures Required by Law.** We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

**2. Public Health Activities.** We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**3. Victims of Abuse, Neglect or Domestic Violence.** We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

**4. Health Oversight Activities.** We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

**5. Lawsuits and Legal Actions.** We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

**6. Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

**7. Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

**8. Organ, Eye and Tissue Donation.** We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

**9. Research Purposes.** We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

**10. Serious Threat to Health or Safety.** We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

**11. Specialized Government Functions.** We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

**12. Workers' Compensation.** We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

## **VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information**

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

## **VII. Your Rights with Respect to Your Health Information**

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

### **A. Right to Access and Review**

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

### **B. Right to Amend**

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

**C. Right to Restrict Use and Disclosure**

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

**D. Right to Confidential Communications, Alternative Means and Locations**

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

**E. Right to an Accounting of Disclosures**

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

**F. Right to a Paper Copy of this Notice**

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

**G. Right to Receive Notification of a Security Breach**

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

**VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information**

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

**IX. Our Right to Change Our Privacy Practices and This Notice**

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is January 1, 2015.

**X. How to Make Privacy Complaints**

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

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**Acknowledgement of Receipt**

I acknowledge that I received a copy of Dr. Montgomery's Notice of Privacy Practices.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_





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[info@drmontgomerydental.com](mailto:info@drmontgomerydental.com)

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## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

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Patient name \_\_\_\_\_

Patient number \_\_\_\_\_

Patient address \_\_\_\_\_

Patient phone number \_\_\_\_\_

I authorize the professional office of my dentist named above to release health information identifying me including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services under the following terms and conditions:

1. Detailed description of the information to be released: any dental and medical information needed for treatment
2. To whom may the information be released: Any treating health care professional or person approved by the patient through written or verbal consent.
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual) to communicate in written or electronic form, to aid in more comprehensive and complete care for the patient.
4. Expiration date or event relating to the individual or purpose for the release may occur at anytime with patient request.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated \_\_\_\_\_ Patient signature \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority \_\_\_\_\_