

Florida Health Care Plans- Dental

Comprehensive Dentistry—Esthetic, Restorative & Preventive

2777 Enterprise Road, Orange City, FL 32763

Ph: 386-481-6886 Fax: 386-774-6638

Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- ✓ We truly care about our patients and we are confident you will feel very comfortable with our entire staff.
- ✓ We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- ✓ The time that you reserve with us is yours and yours alone.
- ✓ We strive to be thorough in everything we do, taking the time to be the best we can be.
- ✓ We are esthetics oriented, helping you look your best, while maintaining optimum comfort, function and health.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation, take necessary x-rays and gather information to make a customized plan for you. This will take approximately 60-90 minutes. Enclosed you will find our new patient information forms. Please fill them out and bring them with you or mail or fax them to our office along a list of any medications that you take and a copy of any dental benefit card you might use. Please feel free to call our patient coordinator at - **386-481-6886** with any questions you might have.

Please see map for your convenience. We are located inside the [Florida Health Care Plans](#) building in Orange City. Our suite is next to the pharmacy in the front half of the building.

We look forward to meeting you.

Sincerely,

Vamsi Kallepalli DMD & Staff



DENTAL CLINIC

FLORIDA HEALTH CARE PLANS

Med. Rec. #: _____

Date: _____

Phone: _____

Name: _____ Cell Phone: _____

Address (Street Address/Apt. #): _____

City/State/Zip: _____

Employer: _____ Business Phone: _____ Extension: _____

Occupation: _____ Height: _____ Weight: _____ Date of Birth: _____

If married please list spouse's name and work phone number:

_____ Business Phone: _____ Extension: _____

In case of emergency call:

_____ Phone: _____

If you are completing this form for another person, what is your relationship to that person?

PLEASE ANSWER EACH QUESTION:

CIRCLE ONE:

1. Have you ever been diagnosed as having cancer? Yes No
 If yes, area of body: _____ Date Diagnosed: _____
 Type of treatment: (circle treatment) X-ray, Surgery, Chemotherapy, Medicine
2. Have you been a hospital patient during the past 2 years? Yes No
 If yes, please explain: _____
3. Have you been under a physician's care during the past 2 years? Yes No
 If yes, please explain: _____
4. Are you taking any kind of medicine regularly or at this time? Yes No
 If yes, please list: _____
5. Are you allergic to any drugs or medicine? Yes No
 If yes, please list: _____
6. Have you ever had excessive bleeding requiring special treatment? Yes No
7. CIRCLE any of the following which you have had now or have had in the past. If yes, please list year.

heart trouble	jaundice	arthritis	HIV Positive
heart problems or defect from birth	asthma	stroke	pins in joints
heart murmur	anemia	diabetes	joint replacements or implants
persistent cough	tuberculosis	epilepsy	mitral valve prolapse
high blood pressure	hepatitis	sinus trouble	latex allergy
psychiatric treatment	rheumatic fever	AIDS	Other _____
8. Have you had any other serious illnesses? Yes No
 If yes, what? _____
9. (Women) Are you pregnant now? Yes No
10. Are you ill today? Yes No
11. Have you ever taken any osteoporosis medications, such as Fosamax, Actonel, Boniva, Reclast, Prolia or Xgeva? Yes No

COMMENTS:

Reviewed by: _____ Patient Signature: _____

PATIENT QUESTIONNAIRE

We are happy to have you join our great family of patients and friends. Please complete this questionnaire for us to better understand your needs and concerns, so we can provide the best care possible for you.

NAME:

DATE:

DATE OF BIRTH:

1. What is your primary dental concern?

2. Do you have any dental anxieties? If so, what is the origin of your anxiety?

3. On a scale of 1-10 (10 being the best) how do you feel about the condition of your mouth? _____
4. On the same scale how would you like it to be? _____

5. Have you been diagnosed with gum disease in the past? _____
If you have undergone any treatment for the same, please specify kind of treatment.

6. Are you aware if you clench or grind your teeth? _____
If so, please specify any treatment you have had for the same.

7. If you could change your smile, what would you change?

8. Does your smile have a positive effect in your work and social life?

9. If you could have your teeth whitened, would you be interested?

10. Please tell us how you learned about our practice.

Referred by employer

Referred by friend/family - _____

Name and Relationship

Through your insurance

Other (please specify)

DENTAL OFFICE FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

Florida Health Care Plans Medical Billing Department is responsible for processing the billing for dental services rendered to you. If you have a balance due for dental services rendered, you will receive a statement from Florida Health Care Plans.

If you do not have insurance or do not want us to submit your charges to your insurance company, full payment is due at time of service. We accept cash, checks, debit and credit cards. There will be a charge for each returned check. Balances not paid within 60 days from the date of service may be turned over to a collection agency.

Regarding your insurance:

If the dentist you are seeing is a participating provider under your insurance plan and if the services you are receiving are expected to be covered expenses, we will gladly file your insurance claim for you. You will need to present your current insurance card and provide any additional information that may need to be necessary to file your claim. **You will be required to pay the estimated portion of the bill that you will be responsible for at the time of service. Upon receipt of remittance from your insurance company, the remaining account balance will be transferred to your responsibility. You will receive a statement at that point detailing the charges due. This statement balance will be due immediately. Balances that are not paid within 60 days from the statement date may be forwarded to collection.**

We are committed to providing the best treatment for our patients and our charges are based on what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Each appointment you make is customized for you and our staff starts preparing for your appointment the previous day .On the day of your appointment the office is staffed depending on your appointment needs. Please give at least 24 hours advance notice when cancelling or changing appointments. Due to the preparation that takes place for your appointment failure to notify less than 24 hours will result in you being charged a cancellation fee up to in full for the appointment.

Thank you for understanding our financial policy. If you have any questions or concerns, please speak with a member of our staff or contact the billing office at 386-676-7124.

I have read the financial policy and understand and agree to this financial policy.

Signature of Patient or Responsible Party

Date

FLORIDA HEALTH CARE PLAN, INC.
NOTICE OF PRIVACY PRACTICES
Effective January 1, 2011

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 Pledge Regarding Protected Health Information

Florida Health Care Plans (FHCP) creates a record of the care and services you receive from FHCP. We need this information to provide you with quality care, administer your health care benefits, and comply with certain legal requirements. This notice applies to all of the records containing protected health information generated by FHCP. We understand that medical information about you and your health is personal and we are committed to protecting it.

Florida Health Care Plans (FHCP) will take every reasonable action to protect your health care information including the protection of your verbal, written, and electronic protected health information (e-PHI) using all means necessary while ensuring that the information is readily available to the providers that deliver your health care. FHCP implements appropriate administrative, technical, and physical safeguards to protect your health information across the organization from unintended or unauthorized use, disclosure, modification or loss.

Introduction/Overview

This Notice of Privacy Practices describes how FHCP 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. This notice describes the privacy practices of FHCP including:

- All divisions and departments of FHCP.
- All employees, staff and other FHCP personnel.
- All FHCP volunteers and auxiliary staff.

Uses and Disclosures of Protected Health Information for Treatment, Payment or Health Care Operations

Your protected health information may be used and disclosed by FHCP's staff and others outside of our office that are involved in the delivery of health care services and benefits. Your protected health information may also be used and disclosed to pay your health care bills and to support FHCP's operations.

Following are examples of the types of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with third parties. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: We may use or disclose your protected health information, as needed, to bill or make payment for your health care services. This may include certain activities that we take before we approve or pay for your health care services such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may ask for a copy of your medical record from a hospital where you received services to ensure that their bill was appropriate.

Health Care Operations: We may use or disclose, as-needed, your protected health information in order to support FHCP's business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and educational activities, and conducting or arranging for other business activities.

For example, we may use your protected health information during medical utilization reviews. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., case management, out-of-area claims re-pricing). Whenever an arrangement between FHCP and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives. We may also use and disclose your information for educational activities. For example, your name and address may be used to send you a newsletter.

Disclosures of Protected Health Information (PHI) to Plan Sponsors:

It is Florida Health Care Plans (FHCP) policy to not disclose PHI to plan sponsors such as a member's employer. FHCP may provide plan sponsors summary health information in a form that has been de-identified. De-identifying health information includes removing things such as name, date, diagnosis, address, medical record number, and any other unique identifying number or characteristic. This information may be used for obtaining insurance quotes or verifying enrollment status to ensure appropriate billing.

Uses and Disclosures of Protected Health Information Based upon Your Written 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, at any time, in writing, except to the extent that FHCP has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Required and Permitted Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

In certain situations we are required or permitted to use or disclose your protected health information. Your authorization is not required for the following uses or disclosures:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on FHCP's premises, and (6) medical emergency (not on FHCP's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we 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. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized by and to the extent necessary to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et seq.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we, using our professional judgment and experience, may determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant will be disclosed. We may use and disclose your protected health information in the following instances.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

If it is in Your Best Interest: Unless you object, we may use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

Disaster Relief: Unless you object, we may use or disclose your protected health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts.

Your Rights

Following are your rights with respect to your protected health information. You may exercise any of these rights by contacting our Member Services Department as described at the end of this Notice.

You have the right to inspect and/or copy your protected health information. This means you may inspect and/or obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. Applicable copying fees apply. A “designated record set” contains medical and billing records and any other records that FHCP uses for making treatment and benefit administration decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

FHCP is not required to agree to a restriction that you may request prohibiting FHCP from using your protected health information for the purposes of treatment, payment or health care operations. If FHCP believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If FHCP does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to have FHCP amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, health care operations, or authorized disclosures as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures made by FHCP in the six years prior to your request, but, no earlier than the effective date of this Notice, April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Inquiries about This Notice, Exercise of Privacy Rights, And Complaints: If you have a question about this Notice, or you wish to exercise your rights described in this Notice, or you believe your privacy rights have been violated, you may contact us at: Florida Health Care Plans, Member Services Department, 1340 Ridgewood Avenue, Holly Hill, FL 32117 or call us at (386) 615-4022, Toll free (800) 352-9824, TTY/TDD (386) 615-4045 or (877) 260-8312. Hours of Operation: 8:00 a.m. – 5:00 p.m.

All complaints must be submitted in writing. You will not be penalized for filing a complaint. A complaint may also be filed with the U.S. Department of Health and Human Services at the following address: Office for Civil Rights, U. S. Department of Health and Human Services, 61 Forsythe Street, S.W., Suite 3B70, Atlanta, GA. 30323 – Voice: (404) 562-7886, TDD: (404) 331-2867, FAX: (404) 5-788

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization except to the extent that FHCP has taken an action in reliance on the use or disclosure indicated in the authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement

The undersigned acknowledges that he/she has reviewed and received a copy of Florida Health Care Plans' *Notice of Privacy Practices*.

Name: _____

Street Address: _____

City, State, Zip Code: _____

Signature:

Date

Photography Release

I hereby authorize Dr. Vamsi Kallepalli to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature

Date

Please read and sign if you will be using Dental Insurance.

Vital Information about your Dental Insurance

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state laws. Your Employee Benefits Director or your insurance agent can usually help you become familiar with your plan and its' restrictions, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary re-file your insurance a second time within a 60-day period.

Your responsibilities:

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with necessary information concerning your insurance coverage to allow correct filling of claims.
3. **To understand that your plan is a contract between you and your employer and the insurance carrier.**

Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.

4. To pay any account balance not paid by insurance after 2 billing attempts.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign this form below.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. **I understand that I am ultimately responsible for all costs of dental treatment.** I grant the right to the dentist and dental office to release my dental/medical histories and other information about my dental treatment to third party payers.

Patient or Insured

Date