



Pentino DENTAL

Creating Beautiful Smiles With a Caring Touch

Alex M. Pentino D.D.S.

We would like to take this opportunity to welcome you to Pentino Family Dental!

Our goal is to exceed your expectations in a welcoming, honest, and compassionate dental office. We take great pride in providing state of the art technology that gives patients of all ages efficient and affordable dental care. We promise to always treat you with kindness and open communication that will allow us to not only meet but exceed your oral health goals for many years to come.

Please review the following information and if you have any questions please do not hesitate to call us. We look forward to meeting you!

The First Appointment

On the first appointment a thorough examination in all areas of your mouth will be done. This will include a detailed examination of the teeth, soft tissue, supporting structures, alignment, bite, and oral cancer check. Based on your dental situation we will let you know what records are necessary so the doctor may accurately assess your dental needs. We think you will agree that the examination appointment is time well spent. If your oral needs are very limited we may combine this appointment with a traditional cleaning. If a more comprehensive evaluation and cleaning are required we will schedule them at this time.

Preventive Oral Hygiene Appointment

After your examination, you will be ready to schedule your preventative oral hygiene session. At this time you will be exposed to the latest theories and techniques for controlling periodontal disease. Specific approaches will be recommended for your individual needs. Your teeth will be cleaned by a professional who is dedicated to you receiving maximum longevity from your natural dentition. This program is clearly one of the most valuable services we offer our patients.

Dental Evaluation and Plan for Treatment

After your preventative appointment you will receive an outline of your dental evaluation and plan for treatment. Immediate needs as well as long-term objectives will be outlined. Again, our recommendations will be based upon a goal of you receiving maximum longevity from your natural teeth.

Except in cases of very minor treatment needs, an estimate of the approximate costs of treatment will also be made at this time. You are encouraged to ask any questions you have concerning your dental care. We believe that successful treatment is always based on a firm understanding of your dental situation. Moreover, if at any time you are uncertain about what your **estimated patient financial responsibility** is, please ask one of our financial and treatment coordinators.

107 Plaza Drive Ste F, St. Clairsville, OH 43950

Phone (740)-695-5700

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Financial Arrangements

Payment is expected at time of service. Our financial coordinator will help you with using our Credit Card processing service or other financial arrangements when extensive dental care is necessary. We will be sensitive to your financial circumstances within the framework of sound business practices. We want to be concerned with your dentistry, not financial responsibilities. Additionally, certain types of appointments may require a deposit. This will be discussed prior to scheduling. All appointments require a valid credit or debit card on file. Cards will not be charged without notification and authorization. Please complete the form at the end of this letter.

A Word about Dental Insurance

We participate with many dental insurance plans and as a courtesy we will submit your claims for you. Your insurance policy is a contract between you and your insurance carrier so, we expect you to be interactive with your insurance plan and be responsible for understanding your insurance benefits. In this regard we would like to offer the following tips:

1. We do our best to calculate your **estimated patient financial responsibility** by using your insurance's "automated" system.
2. Your **estimated patient financial responsibility** is expected at the time of service. You are responsible for any amount not covered by your plan.

In the event your insurance carrier does not cover a service we provided or if there is a balance after your insurance has made their payment you are responsible for the remaining account balance.

Treatment and Procedures

Our office is dedicated to providing our patients with the latest breakthroughs in dental procedures and technology. Please visit our website, www.PentinoDental.com, to view educational videos and images of the amazing procedures that our team offers. In some situations, the doctor may feel that your needs are best treated by using one of the local dental specialist. We work closely with our specialists to provide you with the best standard of care for any situation.

Missed Appointments and Last-Minute Cancellations

Your appointment time has been specifically reserved for you. To avoid a last-minute cancellation or missed-appointment fee we must receive **48** hours advance notice to reschedule. In the event this notice is not received your account will reflect a missed appointment fee based upon the length and type of your appointment. We urge patients to "**opt-in**" to our confirmation service via text message or email. In addition, we always give a courtesy phone call/text up to one week prior to your appointment.

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The Recall Visit

Upon completion of your dental treatment we will place you in our continuing care program and pre-schedule for your Periodic Recall. These appointments are designed to prevent little problems from becoming big or expensive ones. Preventive dentistry is the best and least expensive dentistry, but is easily overlooked or postponed. Don't Miss Your Check-Up! If you think you may be overdue for this important service, please call us and we will verify it for you.

HIPPA - Health Insurance Portability and Accountability Act

Please view our HIPAA notice of privacy practices form and HIPAA Authorization forms found at www.PentinoDental.com.

Please take the time to complete your medical history form included in this letter as well as "check off" and sign your first appointment check list!

It is our goal to make your visit to our dental practice as convenient and comfortable as possible. We sincerely value your patronage and look forward to serving you and your family!

Sincerely,

Alex M. Pentino D.D.S.

BY SIGNING OUR **NEW PATIENT CHECKLIST** YOU ARE ACKNOWLEDGING THAT
YOU HAVE READ AND UNDERSTAND THESE POLICIES

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of Alex M. Pentino D.D.S. 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. To Insurance providers that are helping to cover the cost of your treatment:
2. To any medical professional or dental laboratory that will be directly involved in your treatment, or medical professionals that has an area of expertise that will assist in your medical treatment:
3. To only release information that is pertinent to the direct treatment of your healthcare:
4. This authorization for release will expire after 5 years or if changes are made that require your notice :

It is completely your decision whether or not to sign our **new patient checklist** acknowledging the authorization of this form. We cannot refuse to treat you if you choose not. If you sign the **new patient checklist** acknowledging the authorization of this form, 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 address at the top of the form or to our email address. 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. [For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

BY SIGNING OUR **NEW PATIENT CHECKLIST** I AM ACKNOWLEDGING THAT I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING THE NEW PATIENT CHECK LIST VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

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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.

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;

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- 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, text, E-mail, 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.

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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 required. 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.

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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 at the address or fax 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 please do not hesitate to call.

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New Patient Appointment Check List

___ Bring One Form of Photo Identification – Type: _____ ID #: _____

___ Completion of Medical History

___ Proof of Insurance

___ Valid Credit or Debit Card and Completed Authorization Form

___ I have read and understand Pentino Dental financial policy

___ I have read and agree to Pentino Dental HIPAA Authorization and Notice
of Privacy Practices.

___ I give Pentino Dental the permission to speak with the following
individual regarding my financial, medical, treatment and emergency
information.

(Please print the individual's name and list the relationship)

We are excited to meet you and please do not hesitate to call us at 740-695-5700 or email
us at pentinodds@gmail.com if you have any questions at all!

Patient Signature _____ Date _____

Received by:

Pentino Family Dental Staff Signature _____ Date _____

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