



### **Important Information for New Patients of Community Dental**

1. In order to best serve you as a patient of Community Dental please complete the attached paperwork and bring or mail it to the center where you are seeking services.

**Community Dental Biddeford**, 57 Barra Rd., Suite 3, Biddeford, ME 04005 (207) 282-1305

**Community Dental Farmington**, 131 Franklin Commons, Ste I, Farmington, ME 04938 (207) 779-2659

**Community Dental Lewiston**, 177 Main St., Lewiston, ME 04240 (207) 777-7442

**Community Dental Portland**, 190 Park Ave., Portland, ME 04102 (207) 874-1028

**Community Dental Rumford**, 60 Lowell St, Rumford, ME 04276 (207) 369-3600

2. On the day of your appointment, please arrive **10 minutes before** your appointment time. It is required that you bring your **insurance card** with you to each appointment.
3. A **parent or guardian** must accompany patients under 18 years of age and remain at the Center during the length of the appointment.
4. **Payment** for dental services is due at the same time you receive the dental care. There is a \$25 fee for any check payments returned for non-payment.
5. If you are requesting consideration for our income based **sliding fees**, you must complete the sliding fee application and include copies of all proof of household income. This may include:
  - **A copy of your most recent Tax Return, current household W-2s or pay stub(s) that includes year to date income total.**
  - **A copy of your TANF Check, SSI/SSDI Check, Retirement Check, VA Benefits or Bank statement of Direct Deposit for any of the above**
  - **Alimony, child support payment, City or General Assistance Voucher**

Proof of income must be updated annually. Full fees will be applied if documentation is not received with application.

### **Important Broken Appointment Notice**

Missed appointments prevent patients from getting the care they need. Community Dental may restrict patients from scheduling appointments if they have broken an appointment. An appointment is considered to have been broken if:

1. The patient **fails to appear** for the appointment, or
2. The patient **arrives too late** for a scheduled appointment, or
3. The patient cancels an appointment with **less than 24 hours notice**

[www.communitydentalme.org](http://www.communitydentalme.org)

[www.facebook.com/communitydentalmaine](http://www.facebook.com/communitydentalmaine)



## Community Dental Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/20/2014, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

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

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

### Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

### Your Health Information Rights

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

### Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Susan Isenman  
Telephone: 207-874-1025, ext 3014 Fax: 207-874-1191  
Address: 366 US Route 1, Falmouth, ME 04105  
E-mail: susan.isenman@communitydentalme.org

### PATIENT INFORMATION

Today's date:	Last Name:	First:	Middle:
Date of Birth:	Social Security no:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital status:
Mailing Address:		City:	State:      Zip:
Primary Phone:	Cell: <input type="checkbox"/> Y <input type="checkbox"/> N	Secondary Phone:	Cell: <input type="checkbox"/> Y <input type="checkbox"/> N
Preferred Email:	<small>By providing your email, you are consenting to allow Community Dental to communicate with you about appointments and promotions. We will not sell or otherwise provide your email address to anyone for any reason. You may "opt out" at any time by clicking on the link in any email message we send to you or by calling our office.</small>		

How did you hear about our office:

Please circle the number (only one) of the racial category that pertains to you (optional):	Are you Hispanic or Latino?  <input type="checkbox"/> Y <input type="checkbox"/> N
1. American Indian or Alaskan Native    2. Asian                      3. Black or African- American    4. African	
5. Native Hawaiian or Pacific Islander    6. White/Caucasian    7. Some other Race                      8. Two or more Races	

### PARENT/GUARDIAN INFORMATION

Fill this section out if the patient has not reached the age of 18

<input type="checkbox"/> Parent <input type="checkbox"/> Guardian			
Last Name:	First:	Middle:	
Date of Birth:	Social Security no:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital status:
Mailing Address:		City:	State:      Zip:
Primary Phone:	Cell: <input type="checkbox"/> Y <input type="checkbox"/> N	Secondary Phone:	Cell: <input type="checkbox"/> Y <input type="checkbox"/> N


Is anyone else authorized to bring the above patient to appointments and consent to treatment?  Y  N

If yes, please provide name, relationship to patient, and phone number:

Name:                                      Relation to Patient:                                      Phone:

### IMPORTANT POLICY STATEMENTS

1. I authorize Community Dental and/or any entity authorized by Community Dental, including those using automated dialing systems, verbal and/or automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.
  
2. I understand that only a patient who has reached the age of 18 or a parent/legal guardian may obtain a patient's personal, appointment, billing, or care information. Any requests for records or information that would be sent out of our office would require a written authorization prior to release of the records or information. It may take up to 2 weeks to prepare and mail records or information after a release has been signed.
  
3. I understand that missing appointments without at least 24 hours notice, for any reason, may result in the loss of scheduling advanced appointment times. I may be required to wait, on a stand by basis, for care or I may be dismissed from the practice.

 Patient Signature <i>(Parent/Guardian for those under 18)</i>	Date
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### PATIENT HEALTH INFORMATION

Today's date:	Last Name:	First:	Date of Birth:
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How would you rate your dental health?  Excellent  Good  Fair  Poor    How often do you brush: \_\_\_\_/Day    Floss: \_\_\_\_/Week

Who was your last dentist? \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ Do you have dental anxiety?  Y  N How Severe? (1-10) \_\_\_\_\_

Have you had any problems with previous dental treatment?  Y  N If yes, please explain: \_\_\_\_\_

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How would you rate your overall health?  Excellent  Good  Fair  Poor    If you are Pregnant: Due Date: \_\_\_\_\_

Who is your primary doctor? \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_

What pharmacy do you use? \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list medications and dosage: \_\_\_\_\_

\_\_\_\_\_

Please list all allergies \_\_\_\_\_

Please list all hospitalizations: \_\_\_\_\_

Please list all prosthetics (joints, valves, pins, stents etc) with dates: \_\_\_\_\_

Please list heart attack or strokes with dates: \_\_\_\_\_

Does your doctor want you to take antibiotic pre-medication before dental treatments?  Y  N If yes, for what condition: \_\_\_\_\_

Have you been denied giving blood for any reason?  Y  N If yes, please explain: \_\_\_\_\_

Have you had any bleeding requiring special treatment?  Y  N    Do you take Coumadin or other blood thinner?  Y  N


Have you ever had radiation or chemotherapy treatments?  Y  N    Have you ever taken oral or IV bisphosphonates?  Y  N

Please check if you have been treated for any of the following conditions:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Alcohol/Drug Use	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Growths/Tumors	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Artificial Joints/Pins	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Asthma/Breathing issues	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Herpes	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Other: _____

### FAMILY HEALTH INFORMATION

Relation:	Alive:	Age:	Mental Health	Cancer	Diabetes	Heart/Vascular Disease	High Blood Pressure	Poor Dental Health	Other
Father	<input type="checkbox"/> Y <input type="checkbox"/> N								
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N								
Brother	<input type="checkbox"/> Y <input type="checkbox"/> N								
Sister	<input type="checkbox"/> Y <input type="checkbox"/> N								
Son	<input type="checkbox"/> Y <input type="checkbox"/> N								
Daughter	<input type="checkbox"/> Y <input type="checkbox"/> N								
Other	<input type="checkbox"/> Y <input type="checkbox"/> N								

 <b style="font-size: 1.2em;">Patient Signature</b> <i>(Parent/Guardian for those under 18)</i>	<b style="font-size: 1.2em;">Date</b>
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## Patient Insurance and Income

### INSURANCE INFORMATION

Today's date:	Last Name:	First:	Date of Birth:
Does this patient have insurance? <input type="checkbox"/> Y <input type="checkbox"/> N    If YES, please continue.    If NO, continue to next section			
Is the patient covered under MaineCare? <input type="checkbox"/> Y <input type="checkbox"/> N		MaineCare ID#:	
Is the patient covered by Dental Insurance? <input type="checkbox"/> Y <input type="checkbox"/> N		Insurance ID#:	
Dental Insurance Company Name:		Insurance Company Phone Number:	
Subscriber Name:		Relationship to Patient:	
Subscriber DOB:	Subscriber SS#:	Subscriber Phone Number:	
Subscriber Employer Name:		Group #:	
I hereby authorize payment of dental benefits to Community Dental. I agree to be responsible for all charges and services and materials not paid by my dental plan and/or Maine Care. To the extent permitted under applicable law, I authorize release of any information relating to my dental claims.			
<b>Patient Signature</b> <i>(Parent/Guardian for those under 18)</i>		<b>Date</b>	

### SLIDING FEE APPLICATION

Community Dental has limited assistance available to **patients and families who are *not covered* by dental insurance**. If you would like to be considered for reduced fees, please provide us with your household income. Proof of income is required and must be updated each new calendar year to continue to receive reduced fees.

Type of income	Applicant	Spouse/Partner	Dependents
Weekly/Monthly Wages			
TANF/SSDI etc			
Pension/VA Benefit			
Child Support/Alimony			
Unemployment/Worker's Comp			
Other:			
Please list all household members first names and ages:			

I understand that Community Dental is funded by limited public and private sources and that approval of my application does not obligate Community Dental to discount my care if funds are not available. I certify that this is a true and accurate statement of my income at this date. **I am enclosing a copy of my check stub or other verification of income.**

<b>Patient Signature</b> <i>(Parent/Guardian for those under 18)</i>	<b>Date</b>
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**FINANCIAL POLICY**

Today's date:	Last Name:	First:	Date of Birth:
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**Payment in full is due at the time services are rendered.** While we will submit a claim to your insurance company on your behalf as a courtesy, please not the following:

- You must provide valid evidence of coverage by presenting a current insurance card at each appointment.
- You are responsible for signing the attached assignment of benefits form.
- You are responsible for any deductibles, co-payments and co-insurance amounts at the time of service.
- Amounts paid at the time of service are an **estimate only**. You are responsible for any remaining balance due after your insurance company has processed your claim, including services not covered by your dental policy.
- You are responsible for understanding the individual provisions of your dental policy.
- You are responsible for any amounts over your yearly contracted benefit. For example, if your annual benefit is \$900 and you have already submitted \$900 of claims, you will be responsible for 100% of our fee.
- If you are a MaineCare patient, you are financially responsible for all non-covered MaineCare services.

If your account with Community Dental becomes delinquent, it may be sent to a collection agency, who may in turn report the history of your account to credit reporting agencies.

**If you have any questions about this payment policy please call our office prior to your appointment.**

Statement: By signing this form, I acknowledge I have read and understand the Community Dental financial policy, and I consent to the policy.

 **Patient Signature** *(Parent/Guardian for those under 18)*      *Date*

**ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

Statement: By signing this form, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

If patient is under 18, please print the name of Parent/Guardian:

 **Patient Signature** *(Parent/Guardian for those under 18)*      *Date*

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: (Please specify)

\_\_\_\_\_

\_\_\_\_\_

Staff signature: \_\_\_\_\_ Date: \_\_\_\_\_