POST FALLS PERIODONTICS
& IMPLANT DENTISTRY
DR. JOSEPH MCCOMBS, DDS, MS

602 N Calgary Court, Suite 102, Post Falls, Idaho 83854 Phone (208)777-1796 Fax (208)777-1733

Patient Information

Patient Name _____Sex M/F

Social Security Number_____Date of Birth_____

Mailing Address _____City _____State_____ Zip Code_____

E-Mail_____

Home Number_____ Cell Number _____Work Number_____

Receive text correspondence Y/N Receive email correspondence Y/N

Emergency Contact_____ Relationship to Patient _____

Home Number_____ Cell Number_____

Referred By _____Family Dentist _____

What is the purpose of your visit? _____

Have you been seen or treated at Post Falls Periodontics? Y/N

PRIMARY DENTAL INSURANCE COVERAGE

Insurance Company _____ Phone Number _____

Subscriber Name _____ Subscriber Social Security Number_____

Group Number _____ID Number _____

Subscriber's Date of Birth _____Subscriber's Employer _____

Relationship to Patient _____

SECONDARY DENTAL INSURANCE COVERAGE

Insurance Company _____ Phone Number _____

Subscriber Name _____Subscriber Social Security Number_____

Group Number _____ ID Number _____

Subscriber's Date of Birth _____ Subscriber's Employer_____

Relationship to Patient_____

I authorize my insurance company benefits to be paid directly to Post Falls Periodontics. I am financially responsible for any balance due, including services exceeding the limitations of my insurance policy. I authorize Post Falls Periodontics or Insurance company to release any information requested for claims.

Signature of Patient or Legal Guardian

_____ Date_____

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Financial Policy and Acknowledgment

Thank you for choosing Post Falls Periodontics and Implant Dentistry as part of your dental healthcare team. The following is a statement of our Financial Policy. Please read, agree to and sign prior to any treatment. If you have any questions regarding this policy, please do not hesitate to ask any member of our business team.

Fees:

We are committed to providing you with the highest quality care. Our fees are a reflection of the quality of care we provide. We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, VISA, American Express and CareCredit.

Missed, Late, No-Show or Canceled Appointments: Please note that our business days are Monday- Thursday. Please arrive 15 minutes early for your appointment. If you are late, we may not be able to see you and your appointment may be rescheduled.

Evaluations: Please provide us with a minimum of 2 business day's notice if you are unable to keep your appointment. Our business days are Monday- Thursday. We understand unforeseen circumstances may arise, which may result in canceling or missing your appointment. **A charge of $50.00** may be assessed for multiple missed, short notice or canceled appointments.

Perio Maintenance: Please provide us with a minimum of 2 business day's notice if you are unable to keep your appointment. Our business days are Monday- Thursday. We understand unforeseen circumstances may arise, which may result in canceling or missing your appointment. **A charge of $75.00 may be assessed for missed appointment**, short notice or canceled appointments.

Scaling and Root Planing: Please provide us with a minimum of 3 business day's notice, if you are unable to keep your appointment. Our business days are Monday- Thursday. We understand unforeseen circumstances may arise, which may result in canceling or missing your appointment. **A charge of $150.00 may be assessed for missed,** short notice, or canceled appointments.

Surgical Appointments: Surgical appointments require a minimum of 4 business days' notice for all cancellations, our business days are Monday- Thursday. **A $1000.00 nonrefundable deposit** is required to reserve a surgical date. This deposit will be credited to the fees for treatment. Larger surgical cases or cases with perishable supplies will be charged a percentage of the entire case in addition to forfeiture of the deposit. Our office will inform you regarding these cases. No future appointments can be scheduled, nor can records be transferred without the payment of this fee.

Minors:

The parent or legal guardian of a minor receiving treatment is responsible for full payment at the time of service. Unaccompanied minors must have all treatment consents and payment arrangements completed prior to the scheduled appointment.

Insurance:

As a courtesy to you, we will submit the claim on your behalf to your dental insurance. We are unable to provide an estimate of coverage for companies we are not partnered with. We will provide an insurance estimate to you Delta Dental; however, it is not a guarantee that your insurance will pay exactly as estimated. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.

Our practice is committed to providing the best treatment for our patients and we charge 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.

By signing below, you authorize the release or your (or your child's) healthcare advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. **We require any applicable deductibles and estimated patient portion be paid at the time of service.** Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. Our office will make contact regarding claim status. If payment is not received, or denied, you will be responsible for paying the full amount. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over a claim. We are happy to recreate records upon your request with an assessed fee of $25.00.

Patient / Parent name printed _____

Patient / Parent Signature _____Date_____

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GENERAL CONSENT

Patient Name_____DOB_____

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography. Some of the procedures may be performed by a dental profession other than the dentist including a dental assistant or dental hygienist that have been trained to perform certain tasks and is allowable by Idaho Law.
2. I will provide a thorough and complete medical history, supply a full list of my medications with doses, and consent to my dentist communicating with my medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. Payment is due the day of service and I am responsible for the full amount owed regardless of any insurance policy I may or may not have. The practice will help in filling any forms needed for insurance reimbursement and those payments will be given to the patient. There is no guarantee that an insurance company will cover work that may be performed.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.
7. Most dental procedures require the use of dental anesthetic or numbing to complete the procedure. I understand that there are risks involved in using anesthetic which includes permanent or temporary loss of feeling and muscle control from nerve damage, pain from injection site including muscle tightness or even muscle damage that may or may not go back to the normal, allergic reaction, and any other side effects.

_____ _____
Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____
Date Description of Representative's Authority

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Medical History

Patient Name_____DOB_____

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 currently under the care of a physician?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Are you taking any medication, pills, or drugs?	Yes	No
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No
Are you on a special diet?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances?	Yes	No

Women: Are you…

Nursing?	Yes	No
Pregnant / Trying to get pregnant?	Yes	No
Taking oral contraceptives?	Yes	No

Are you allergic to any of the following?

Acrylic?	Yes	No
Aspirin ?	Yes	No
Codeine?	Yes	No
Latex?	Yes	No
Local Anesthetics?	Yes	No
Metal?	Yes	No
Penicillin?	Yes	No
Sulfa Drugs?	Yes	No
Other?	Yes	No

Do you have any of the following?

AIDS/HIV Positive?	Yes	No
Alzheimer's Disease?	Yes	No
Anaphylaxis?	Yes	No
Anemia?	Yes	No
Angina?	Yes	No
Arthritis/Gout?	Yes	No
Artificial Heart Valve?	Yes	No
Artificial Joint?	Yes	No
Asthma?	Yes	No
Blood Disease?	Yes	No
Blood Transfusion?	Yes	No
Breathing Problems?	Yes	No
Bruise Easily?	Yes	No
Cancer?	Yes	No
Chemotherapy?	Yes	No
Chest Pain?	Yes	No
Cold Sores/Fever Blisters?	Yes	No
Congenital Heart disorder?	Yes	No
Convulsions?	Yes	No
Cortisone Medicine?	Yes	No
Diabetes?	Yes	No
Drug Addiction?	Yes	No
Easily Winded?	Yes	No
Emphysema?	Yes	No
Epilepsy or Seizures?	Yes	No
Excessive Bleeding?	Yes	No
Excessive Thirst?	Yes	No
Fainting Spells/ Dizziness?	Yes	No
Frequent Cough?	Yes	No
Frequent Diarrhea?	Yes	No
Frequent Headaches?	Yes	No
Genital Herpes?	Yes	No
Glaucoma?	Yes	No
Hay Fever Heart Attack/Failure?	Yes	No
Heart Murmur?	Yes	No
Heart Pacemaker?	Yes	No
Heart Trouble/ Disease?	Yes	No
Hemophilia?	Yes	No
Hepatitis A?	Yes	No
Hepatitis B or C?	Yes	No
Herpes?	Yes	No
High Blood Pressure?	Yes	No

High Cholesterol?	Yes	No
Hives or Rash?	Yes	No
Hypoglycemia?	Yes	No
Irregular Heartbeat?	Yes	No
Kidney Problems?	Yes	No
Leukemia?	Yes	No
Liver Disease?	Yes	No
Low Blood Pressure?	Yes	No
Lung Disease?	Yes	No
Mitral Valve Prolapse?	Yes	No
Osteoporosis?	Yes	No
Pain in Jaw Joints?	Yes	No
Parathyroid Disease?	Yes	No
Psychiatric Care?	Yes	No
Radiation Treatments?	Yes	No
Recent Weight Loss?	Yes	No
Renal Dialysis?	Yes	No
Rheumatic Fever?	Yes	No
Rheumatism?	Yes	No
Scarlet Fever?	Yes	No
Shingles?	Yes	No
Sickle Cell Disease?	Yes	No
Sinus Trouble?	Yes	No
Spina Bifida?	Yes	No
Stomach/Intestinal Disease?	Yes	No
Stroke?	Yes	No
Swelling of Limbs?	Yes	No
Thyroid Disease?	Yes	No
Tonsillitis?	Yes	No
Tuberculosis?	Yes	No
Tumors or Growths?	Yes	No
Ulcers?	Yes	No
Venereal Disease?	Yes	No
Yellow Jaundice?	Yes	No

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Have you had a serious illness not listed above? Yes No

Please explain.

Please list any medications you are currently taking.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Representative's Authority

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PATIENT AUTHORIZATION TO RELEASE
CONFIDENTIAL INFORMATION

Patient Name:_____DOB_____

Previous Clinic Name:_____

New Clinic Name:_____

Phone Number:_____

Fax Number: _____

I _____ authorize, to disclose and provide copies of any and all clinical treatment, records, and information concerning my care (or child's if patient is under 18 years of age) which is in the clinic's possession to be sent to the following dentist or entity:

_____

These records include but are not limited to: Patient information, medical and dental history, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related materials. I expressly release from liability the above-named person or entity from any and all liability arising from compliance with this request and disclosure of requested information.

Reason for Transfer: _____

_____ _____

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date	Description of Representative's Authority

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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 the content carefully.
The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.
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. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our Nice 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation

practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except this described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: we may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose you health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use our disclosed health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. 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.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years. 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 these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerts, please contact us.
If you are concerned that we may have violated your privacy rights, or 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 be alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also my 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.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

**You may refuse to sign this acknowledgment.

Name of Patient or Personal Representative	Signature of Patient or Personal Representative
Date	Description of Representative's Authority

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To My Medicare Eligible Patients:

This is to let you know that under a law passed by Congress in 2003, I have decided not to participate in the Medicare system. I believe this decision will allow me to provide the best possible care to you at fees we agree upon. This also permits us to proceed with your treatment without worrying about Medicare limitations or red tape. Very little dental care is covered by Medicare Part B and it is unfortunately very difficult for my office to handle all of the paperwork and red tape of this complex governmental structure. My non-participation in Medicare means you will pay me directly for services covered by Medicare Part B. For this to happen, the law requires us to enter into a contract containing very specific terms.

If you agree that this approach will work for your needs as well, please sign and date the attached contract. I certainly will understand if you decide you do not wish to sign the contract. Please simply note that this would mean I regrettably would be unable to perform any Medicare Part B-covered procedures for you.

Thank you for your understanding. I value you as a patient and value our professional relationship and hope this letter helps you understand the situation.

Sincerely,

Joseph McCombs, DDS. MS.

Medicare Opt Out Private Contract

This contract is between Dr. Joseph McCombs, DDS ("Dentist") and Patient named at bottom of page (Medicare beneficiary, referred to in this contract as "Patient").

Dentist has elected to opt out of Medicare. A dentist who opts out is not required to submit claims on behalf of beneficiaries and is not subject to Medicare limits on charges for covered services.

1. Dentist represents that Dentist is excluded from participation under the Medicare program Under sections 1128, 1156 or 1892 of the Social Security Act.
2. Patient (or Patient's legal representative) and Dentist agree that Patient is not now facing an emergency or urgent health care situation.
3. By signing this contract, Patient (or Patient's legal representative does the following:
    a. Accepts full responsibility for payment of Dentist's charge for all services furnished by Dentist;
    b. Understands that Medicare limits do not apply to what the Dentist may charge for items or services furnished by the Dentist;
    c. Agrees not to submit a claim to Medicare or to ask Dentist to submit a claim to Medicare;
    d. Understands that Medicare payment will not be made for any items or services furnished by Dentist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;
    e. Enters into this contract with the knowledge that Patient has the right to obtain Medicare-covered items and services from dentists, physicians, and practitioners who have not opted out of Medicare, and that Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other dentists, physicians, or practitioners who have not opted out;
    f. Understands that Medigap plans do not, and that other supplemental plans may elect not t, make payments for items and services not paid for by Medicare:
4. The known effective date of the opt-out period is September 16, 2022.
5. The known expiration date of the opt-out period is September 16, 2024.

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of the Dentist's current opt-out period.

___Joseph McCombs DDS _____	_____1801122197_____
Physician/Practitioner Printed Name	Physician/Practitioner Provider Number
_____	_____
Physician/Practitioner Signature	Witness Printed Name
_____	_____
Beneficiary or Representative Name	Witness Signature
_____	_____
Beneficiary or Representative Signature	Date