

John E. Tiano, DDS, PC & Associates

Irwin
7546 Route 30
Irwin PA 15642
(724) 864-2888

Greentree
300 Fleet Street, Suite 200
Pittsburgh PA 15220
(412) 937-9070

West Mifflin
4945 Homeville Road
West Mifflin PA 15122
(412) 466-9466

Monroeville
4077 William Penn Hwy
Monroeville PA 15146
(412) 646-1000

Pleasant Hills
841 Clairton Boulevard
Pleasant Hills, PA 15236
(412) 655-9600

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
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

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, or to family and friends you approve.

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, evaluating 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. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: 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 or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your 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. If you request copies, we will charge you \$25.00 to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

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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 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 with the U.S. Department of Health and Human Services.

A Privacy/Contact Officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy/Contact Officer.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

Print Patient's Name

Date

I, _____, have received
(Signature of Patient)

a copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

I, _____, consent to the use and disclosure of
(Signature of Patient)

my personal health information by your office during Treatment, Billing/Payment and Dental

Office Operations as outlined in the Notice of Privacy Practices.

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Welcome!! We are updating our records and would appreciate your help with the following information. Thank You!

Name _____ Date of Birth _____

Address _____ SS# _____

City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Mobile Phone () _____

Email _____

Primary Dental Insurance Company _____

Insured's Name _____ Date of Birth _____ SS# _____

Employer's Name _____ ID# _____

Secondary Dental Insurance Company _____

Insured's Name _____ Date of Birth _____ SS# _____

Employer's Name _____ ID# _____

Preferred method to contact, and the best way for us to reach you (*please check*):

Home Phone () Work Phone () Mobile Phone () Email ()

AUTHORIZATION

I hereby assign benefits to THE DENTISTRY for any insurance I may have in effect. I hereby authorize THE DENTISTRY to administer such medical and perform such diagnostic and therapeutic procedure as may be necessary for proper dental care. I affirm that the information I have given is correct to the best of my knowledge, and that is my responsibility to inform this office of any changes in my medical status. I have received and read a copy of this office's Notice of Privacy Practice. I understand that I am responsible for all charges for my dental treatment. I understand that if I am behind in making payments, THE DENTISTRY may: (1) hire an attorney to collect the money, AND (2) charge me for the attorney's fees, court costs, services or processing costs, and all other expenses that are associated with the collection of the money from me.

Signature of Patient or Responsible Party

Date

Signature of The Dentistry Staff

Date

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Date: _____

I, _____ give The Dentistry permission to
(patient name)

_____ speak with _____ regarding
(spouse / child / family member / guardian)

any of my financial information or treatment.

Thank You,

(Patient or Guardian Signature)

John E. Tiano, DDS, PC & Associates

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Please mark your responses with an "x"

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- 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 Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain _____

Do you have, or have you had any of the following? (Please circle)

- | | | | | | | | |
|---------------------------|----------|---------------------------|----------|-----------------------|----------|----------------------------|----------|
| AIDS/HIV Positive | Yes / No | Cortisone Medicine | Yes / No | Hemophilia | Yes / No | Radiation Treatments | Yes / No |
| Alzheimer's Disease | Yes / No | Diabetes | Yes / No | Hepatitis A | Yes / No | Recent Weight Loss | Yes / No |
| Anaphylaxis | Yes / No | Drug Addiction | Yes / No | Hepatitis B or C | Yes / No | Renal Dialysis | Yes / No |
| Anemia | Yes / No | Easily Winded | Yes / No | Herpes | Yes / No | Rheumatic Fever | Yes / No |
| Angina | Yes / No | Emphysema | Yes / No | High Blood Pressure | Yes / No | Rheumatism | Yes / No |
| Arthritis/Gout | Yes / No | Epilepsy or Seizures | Yes / No | High Cholesterol | Yes / No | Scarlet Fever | Yes / No |
| Artificial Heart Valve | Yes / No | Excessive Bleeding | Yes / No | Hives or Rash | Yes / No | Shingles | Yes / No |
| Artificial Joint | Yes / No | Excessive Thirst | Yes / No | Hypoglycemia | Yes / No | Sickle Cell Disease | Yes / No |
| Asthma | Yes / No | Fainting Spells/Dizziness | Yes / No | Irregular Heartbeat | Yes / No | Sinus Trouble | Yes / No |
| Blood Disease | Yes / No | Frequent Cough | Yes / No | Kidney Problems | Yes / No | Spina Bifida | Yes / No |
| Blood Transfusion | Yes / No | Frequent Diarrhea | Yes / No | Leukemia | Yes / No | Stomach/Intestinal Disease | Yes / No |
| Breathing Problem | Yes / No | Frequent Headaches | Yes / No | Liver Disease | Yes / No | Stroke | Yes / No |
| Bruise Easily | Yes / No | Genital Herpes | Yes / No | Low Blood Pressure | Yes / No | Swelling of Limbs | Yes / No |
| Cancer | Yes / No | Glaucoma | Yes / No | Lung Disease | Yes / No | Thyroid Disease | Yes / No |
| Chemotherapy | Yes / No | Hay Fever | Yes / No | Mitral Valve Prolapse | Yes / No | Tonsillitis | Yes / No |
| Chest Pains | Yes / No | Heart Attack/Failure | Yes / No | Osteoporosis | Yes / No | Tuberculosis | Yes / No |
| Cold Sores/Fever Blisters | Yes / No | Heart Murmur | Yes / No | Pain in Jaw Joints | Yes / No | Tumors or Growths | Yes / No |
| Congenital Heart Disorder | Yes / No | Heart Pacemaker | Yes / No | Parathyroid Disease | Yes / No | Ulcers | Yes / No |
| Convulsions | Yes / No | Heart Trouble/Disease | Yes / No | Psychiatric Care | Yes / No | Veneral Disease | Yes / No |
| | | | | | | Yellow Jaundice | Yes / No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on his form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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A Word about Missed Appointments:

The nature of our practice is to give our patients the utmost in dental care and service in a sterile and professional environment. We make every attempt to see you at your reserved appointment time. However, since we are sometimes faced with emergencies during the day we may run behind schedule. This happens only on occasion so please excuse any delays. We promise to give you the same careful attention and dedicated time.

In fairness to others and to enable us to efficiently plan the day's schedule, it is necessary that you give us sufficient prior notification if you need to reschedule your dedicated appointment time. In the light of this we have established the following protocol:

There will be a \$30.00 charge for any missed or cancelled hygiene/check-up appointment unless we have been given a 48 hour prior notice.

We thank you for helping our office run as smoothly and efficiently as possible for all patients, and by arriving for your dedicated appointment on time.

Your signature affirms that you have read the above protocol.

Date: _____

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Financial Policy

We appreciate the opportunity to serve you! We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

- **Patients without insurance coverage need to know ...**
The fee for the treatment rendered must be paid in full on the day of service.
 - **Patients with insurance coverage need to know ...**
The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees generated by your treatment.
 - **We accept Visa, MasterCard, checks, and cash for payment of the amount due.**
Payment plans are available. Please ask about them if you need one.
 - **Two business days notice is required for rescheduling appointments.**
A \$75 to \$100 fee, depending on the amount of time that was reserved for you, will be applied to your account for rescheduling, canceling or failing to show up for your appointment without 2 business days notice, Dr. Tiano reserves your appointment time exclusively for you; he doesn't "double-book" and keep extra patients waiting in case you can't come. Please be considerate.
-

This is an agreement between John E. Tiano DDS, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you consent to treatment by John E. Tiano DDS and his staff and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

The Financial policy continues on the back of this page.

Patient's Name: _____

Responsible Party
(if patient is under
18 years old): _____

Signature: _____ Date: _____

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

Treatment Plans: You understand that if Dr. John Tiano, DDS, PC & Associates has treatment recommendations for you, you will receive an itemized list of the recommended treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance, the treatment plan may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. You understand that treatment plan estimates are not a guarantee of insurance payment and you are ultimately responsible for all fees generated by your treatment.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued, and is overdue if not paid by twenty-one (21) days after the statement date.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of (1.0%) to the "overdue balance of your account. The "overdue balance" of your account is calculated by taking the balance owed ninety (90) days ago, and then subtracting any payments or credits applied to the account during that time.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees that we incur plus all court costs.

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

Returned checks: There is a fee (currently \$25) for any checks returned by the bank.

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

Insurance Release: You authorize John E. Tiano DDS PC and Associates to release any necessary information requested by your insurance carrier and authorize payment directly to John E. Tiano DDS PC for any benefits available under your insurance plan.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within ninety (90) days after the date of service, the full amount is due and payable to you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.

Transferring of Records: You may request by phone if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

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

Initials: _____

Date: _____