Dr. Christa D. Spann DMD
5500 Summerville Road
Phenix City, AL 36867

Phone: (334) 297-7100
Fax: (334) 297-7065
www.christadspanndmd.com

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

Social Security Number: _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial: ____

Address *(If different)* _____ Date of Birth _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Social Security Number: _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: ____

Telephone (☐Mobile ☐Work ☐Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications.

I attest to the accuracy of the information on this page.

Signature _____ Date _____
(Responsible Party, if under 18)

PATIENT REGISTRATION

Health Information

Patient Name_____ Date _____

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies

_____
_____
_____
_____
_____
_____

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other:

_____
_____
_____
_____
_____

- ☐ Artificial(prosthetic) heart valve
- ☐ Previous infective endocarditis
- ☐ Damaged valves in transplanted heart
- ☐ Congenital heart disease
  - ☐ Unrepaired, cyanotic CHD
  - ☐ Repaired (Completely) in last 6 months
  - ☐ Repaired CHD with residual defects

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:

_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:

_____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____
Signature of patient, parent or guardian Date

PATIENT NAME: _____ DATE: _____

Dr. Christa D Spann and staff are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- We **PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover or American Express

INSURANCE

Dr. Christa Spann DMD General and Cosmetic Dentistry provides insurance company as a **courtesy** to our patients. Certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon on any information provided by staff members regarding his/her remaining benefit in any such benefit period.

The claims we submit to the insurance companies indicate that you have been assigned those benefits to Dr. Christa D Spann DMD. However, if you are paid by the insurance company instead of Dr. Christa D Spann DMD, you then become responsible for the total account balance and payment would be expected immediately.

The office coordinator will make every effort to provide the closest **ESTIMATE** possible for any treatment plans recommended by this office. However, the patient/responsible party is 100% responsible for payment of all services rendered by Dr. Christa Spann. The treatment plan estimate is an "**ESTIMATE ONLY"** and is **NEVER** a guarantee of payment by the insurance company (THE INSURANCE COMPANY ALSO INFORMS EVERY PERSON THAT CALLS THEM OF THIS "DISCLAIMER."). **You understand and agree that the fees charged are a legal and lawful debt and agree to pay said fees and if the balance due is not paid in full within 90 days your account will be considered delinquent and may be placed with a collection agency. You agree to pay collection agency fees, (33.33%) , attorney fees and/or court costs if such be necessary**

Consent to Contact Debtors On Their Cell Phones

You agree, in order for us to service your account or to collect monies you may owe, the office of Dr. Christa Spann DMD and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

MISSED APPOINTMENTS

This office requires a 24 hour notice if you do not intend to keep a scheduled appointment. Cancellations must be made by speaking with one our staff members. A $40.00 missed appointment fee will be charged for any missed appointment without a 24 hour notice to this office. If there is a coordinated appointment scheduled with another office, it is the responsibility of, the patient, to confirm, reschedule, or cancel in the same ample time in which Dr. Spann's office requires, as there may be fees that apply at the other office.

Responsible Party Signature _____ **Date** _____

FINANCIAL POLICY

Personal Health Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

I authorize the release of any and all information including the diagnosis, financial and dental records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____

PRIVACY POLICY FOR THE OFFICE OF CHRISTA D. SPANN FAMILY DENTISTRY

Christa D. Spann Family Dentistry has in place privacy policies and has always protected the confidentiality of patient information in accordance with the patient's wishes and state and federal laws. The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 2013 Omnibus Rule requires that these policies and procedures be made available to the patients in the form of a "Privacy Policy." The following policy statement is provided to the patients of Christa Spann Family Dentistry hereafter referred to as "Dental Office" in compliance with the requirements of HIPAA resulting regulations. This policy states how your medical information referred to as "protected health information (PHI)," may be used and disclosed, and how you may access that information. Please read carefully and sign.
The office will not use or disclose your PHI without your written authorization except as described in this policy. Dental Office reserves the right to change its practices and this policy and to make the new policy effective for all PHI that we maintain. Upon request, we will provide any policy revisions to you.

The patient may authorize the use of patient's protected health information (PHI) in any way the patient so desires by submitting a request to Dental Office in writing. Office will comply with the patient's instructions within the parameters of State and Federal laws. Office is not required to agree to restrictions on the use of PHI that would interfere with treatment and quality of care.

- Dental Office may discuss PHI with the patient's other health care providers as provided by law, to the extent that such communications pertain to the treatment and quality of care for that patient.
- Current Alabama law requires the release of PHI on a court order or subpoena. Dental office may also release PHI to comply with Alabama Workers Compensation Laws to meet requirements of Public Health Laws and to comply with requirements of law relating to audits, investigations and inspections necessary for Dental Office licensure and for the government to monitor the health care system government programs and compliance with civil rights laws.
- Dental Office will make available to the patient copies of the patient's PHI, upon request including electronic forms such as PDFs etc. There may be a fee for production of records. If you feel that your PHI is incomplete or incorrect, you may request that it be amended. Such a request must include the reason for the request and must be in writing to the Dental Office privacy officer. Your request may be denied. If denied, you have the right to file a statement of disagreement and Dental Office may give a rebuttal to your statement of disagreement.
- Dental Office may leave voice messages or mail/e-mail/text reminders to the patient regarding necessary upcoming appointments or need thereof.
- Dental Office will make every effort to disclose only the minimum necessary information for payment by patient's designated payer or to other business associates necessary to process and transmit PHI to accomplish the provisions of and payment for services and product for the patient's health care. Dental Office will require contracts from those business associates who have access to your PHI as permitted by law.
- Dental Office will not authorize the use of PHI by any person or entity for the purposes of contacting patient for marketing unless specifically authorized by patient.
- For the purposes of providing quality services, personnel, including assistants, hygienists, and office manager, will have access to certain PHI. Our Privacy Officer and Dental Office Privacy committee appointed by Dental Office has trained all such personnel in the confidentiality of PHI.
- Patients who feel that their privacy rights have been violated, are requested to contact our office privacy officer at 334-297-7100.
- All patients will be afforded opportunity to review this policy and a copy will be made available to any patient upon request. The patient will be asked to sign and acknowledgement notice of this Privacy Policy as requested by HIPAA.

Patient Name Printed:

_____

Patient Signature:_____

Date Signed:_____

If Minor, Responsible Party Name Printed:

_____

If Minor, Responsible Party Signature:_____

Witness Signature:_____