



Kimberly Fee D.M.D.

1316 W. Gurley • Prescott, Arizona 86305
928-778-7410 • FAX: 928-771-1157

PATIENT INFORMATION (Please Print)

NAME Dr. Mr. Mrs. Ms. _____
Last First Middle

Child Single Married Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address if Different _____

Home ☎ _____ Business ☎ _____ Ext. # _____ Social Security# _____

Employer _____ Occupation _____

Guardian / Spouse's Name _____ Person Responsible for Bill _____

Dental Insurance Yes No If Yes Group Carrier _____ Group# _____

Name of Primary Insured _____ SS# & DOB of Primary Insured _____

Employer of Primary Insured _____

Has any member of your family been treated in our office? Yes No Name _____

Whom may we thank for referring you to our office? _____

Call in case of emergency _____ Relationship _____ Phone _____

MEDICAL HEALTH

Name and address of Physician _____

Physician's Phone _____ Last complete physical _____

Please check those conditions that now or have ever pertained to you:

YES NO

- ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?
- HEART MURMUR OR CONGENITAL HEART DEFECT
- HEART SURGERY OR HEART DISEASE
- MITRAL VALVE PROLAPSE
- HEART PACEMAKER
- ABNORMAL BLOOD PRESSURE HIGH / LOW
- BLEEDING PROBLEMS
- DIABETES
- KIDNEY DISEASE
- JAUNDICE OR LIVER DISEASE
- CANCER
- HEPATITIS
- HAVE YOU EVER TESTED H.I.V. POSITIVE?
- JOINT REPLACEMENT
- CONVULSIONS OR EPILEPSY
- DIZZINESS OR FAINTING SPELLS
- STROKE
- LUNG PROBLEMS OR TUBERCULOSIS
- THYROID DISEASE
- Drug Addiction

YES NO

- GLAUCOMA
- ULCERS
- ARTHRITIS
- BLOOD DISEASE IE ANEMIA
- SINUS TROUBLE
- ARE YOU PREGNANT?
- HAVE YOU EVER TAKEN ANY DRUGS FOR OSTEOPOROSIS SUCH AS FOSOMAX, BONIVA OR I.V. ZOMETIA OR AREDIA?

ARE YOU ALLERGIC OR SENSITIVE TO:

- PENICILLIN
- ASPIRIN
- CODEINE
- DEMEROL
- LATEX RUBBER
- LOCAL ANAESTHETICS LIKE
- NOVACAINE

ALLERGIES NOT LISTED

- _____
- _____

List all prescription medications you are currently taking:

Medication

Purpose

Kimberly Fee DMD

1316 W Gurley St | PRESCOTT AZ, 86305 | (928) 778-7410

Written Financial Policy

Thank you for choosing Kimberly Fee DMD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- NO INTEREST¹ Payment Plans² from CareCredit
 - o Allow you to pay over time with NO INTEREST¹
 - o Convenient, low monthly payment plans² also available
 - o No annual fees or pre-payment penalties

Please note:

Kimberly Fee DMD requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds for treatments over \$1000.00. For plans requiring multiple appointments, alternative payment arrangements may be provided.

We also offer in-house financing for treatments over \$1000.00. We charge 1.5% interest on all past due accounts.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment.

A fee of \$42.00 is charged for patients who miss or cancel more than 3 times in a calendar year without 24-hour notice.

Kimberly Fee DMD charges \$25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

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Notice of Privacy Practices

This notice describes how health information about you may be used & disclosed along with how you may obtain access to this information.

**Please review this 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. This Notice took effect on 04/01/2003 and will remain in effect until replaced.

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 the 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.

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 treating you.

Payment: We may use and disclose your health information to obtain payment for services we provide 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. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those 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 other 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 circumstances, we will disclose health information based on a 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 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.

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 your 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 official having lawful custody or protected health information of inmate or patient under certain circumstances.

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. 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 beginning of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address on this Notice. If you request copies, we will charge you \$0.50 for each page, \$25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

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 6 years, but not before April 14, 2003. **Restriction:** 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).

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.

QUESTIONS AND COMPLAINTS

If you want more information about your 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 alternate means or at alternative locations, you may complain to us using the contact information at the beginning of this Notice. You may also 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 will 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.

Kimberly W. Fee, D.M.D.
Acknowledgement of Receipt
Notice of Privacy Practices

You may decline signing this acknowledgement should you choose

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Signature & 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:

(circle one)

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- Other (please specify)

- _____

