PATIENT PACKET- DENTAL

PATIENT INFORMATION		
Name:	**Social Security #:**	**Date of Birth:**
Primary Address: (street, city, state, zip)		
Email Address:	**Home Phone Number:**	**Cell Phone Number:**
Ways we can communicate with you (select all that apply): ☐ Home ☐ Portal ☐ Cell # ☐ Text	**Language Preference:**	**Interpreter Needed:** ☐ Yes ☐ No
Emergency Contact Name:	**Emergency Contact Number:**	**Relationship to Contact:**

Legal Sex:	**Gender Preference:**	**Marital Status:**	**Do you think of yourself as:**
☐ Male ☐ Female	☐ Male ☐ Female ☐ Transgender (M to F) ☐ Transgender (F to M) ☐ Other ☐ Choose not to disclose	☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widowed ☐ Separated	☐ Straight (not lesbian or gay) ☐ Lesbian or gay ☐ Bisexual ☐ Other ☐ Do not know ☐ Choose not to disclose

Type of Housing:	**Employment Status:**
☐ Own ☐ Rent ☐ Homeless ☐ Subsidized ☐ Transitional housing ☐ Staying with friends/family ☐ Other shelter	☐ Employed ☐ Unemployed **US Citizen?** ☐ Yes ☐ No **Veteran?** ☐ Yes ☐ No

Race (select all that apply):		**Ethnicity (select all that apply):**
☐ Asian Indian	☐ Native Hawaiian	☐ Mexican/Mexican American/Chicano(a)
☐ Chinese	☐ Other Pacific Islander	☐ Puerto Rican
☐ Filipino	☐ Guamanian or Chamorro	☐ Cuban
☐ Japanese	☐ Samoan	☐ Another Hispanic, Latino(a), or Spanish origin
☐ Korean	☐ Black/African American	☐ Not Hispanic, Latino(a), or Spanish origin
☐ Vietnamese	☐ American Indian/Alaska Native	☐ Choose not to disclose
☐ Other Asian	☐ White/Caucasian	
	☐ Choose not to disclose	

Are you a Migrant Farmworker? *Defined as an individual who is required to be absent from a permanent place of residence for the purpose of seeking employment in agricultural work.* ☐ Yes ☐ No

Are you a Seasonal Farmworker? *Defined as an individual who is employed in temporary farmwork but does not move from permanent residence to seek farmwork; may also have other sources of employment.* ☐ Yes ☐ No

Langley HEALTH SERVICES

Annual Income- Please select the letter that matches your family size and annual income: _____
How many people live in your household? _____

	A	B	C	D	E	F
# of People in Household	100%	125%	150%	175%	200%	>200%
1	$0 - $14,580	$14,581 - $18,225	$18,226 - $21,870	$21,871 - $25,515	$25,516 - $29,160	Over $29,160
2	$0 - $19,720	$19,721 - $24,650	$24,651 - $29,580	$29,581 - $34,510	$34,511 - $39,440	Over $39,440
3	$0 - $24,860	$24,861 - $31,075	$31,076 - $37,290	$37,291 - $43,505	$43,506 - $49,720	Over $49,720
4	$0 - $30,000	$30,001 - $37,500	$37,501- $45,000	$45,001 - $52,500	$52,501 - $60,000	Over $60,000
5	$0 - $35,140	$35,141 - $43,925	$43,926 - $52,710	$52,711 - $61,495	$61,496 - $70,280	Over $70,280
6	$0 - $40,280	$40,281 - $50,350	$50,351 - $60,420	$60,421 - $70,490	$70,491 - $80,560	Over $80,560
7	$0 - $45,420	$45,421 - $56,775	$56,776 - $68,130	$68,131 - $79,485	$79,486 - $90,840	Over $90,840
8	$0 - $50,560	$50,561 - $63,200	$63,201 - $75,840	$75,841 - $88,480	$88,481 - $101,120	Over $101,120
For each additional person, add	$5,140	$6,425	$7,710	$8,995	$10,280	$10,280

Are you interested in applying for the Sliding Fee Scale (if yes, further income verification will be required)?
☐ Yes ☐ No

Pharmacy Name:	**Pharmacy Phone #:**	**Lab Preference:** ☐ Quest ☐ LabCorp ☐ Other

INSURANCE AND GUARANTOR INFORMATION

Primary Insurance:	**Policy #:**	**Group #:**
Subscriber Name:	**Relationship to Patient:**	
Subscriber Date of Birth:	**Subscriber Social Security Number:**	
Secondary Insurance:	**Policy #:**	**Group #:**
Subscriber Name:	**Relationship to Patient:**	
Subscriber Date of Birth:	**Subscriber Social Security Number:**	

CONSENTS AND ACKNOWLEDGEMENTS

Consent for Treatment

I hereby give consent and authorize examination and treatment at Project Health, Inc. d/b/a Langley Health Services (LHS) for myself, the patient, by the personnel at LHS. The need for the examination and treatment, and the possibility of undesirable side effects, will be explained by the employees of LHS. I understand there is no guarantee or assurance, as to the results which may be obtained, but normal prudent care will be exercised by employees for LHS concerning my diagnosis and treatment.

Consent for Treatment of a Minor ***only complete if patient is under 18 years of age***

I, as the parent or legal guardian of the patient, _____, do hereby give my consent and authorize treatment of my child. Furthermore, I grant permission for the following individuals to authorize Medical Treatment in my absence:

1. _____ **Relationship to patient:**_____
2. _____ **Relationship to patient:**_____
3. _____ **Relationship to patient:**_____

Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.

Release of Information

Reasons for releasing a patient's record include, but are not limited to:

- Insurance company(ies), their agents or other third party payor and/or
- Government or social service agencies which may or will pay for any part of the medical/hospital expenses incurred or
- Authorized representatives of Langley Health Services as mandated by law or
- Alternate care providers, including community agencies and services, as ordered by patient's provider or
- As requested by Patient or Patient's family for post-hospital care

Patient acknowledges and agrees that some, or all, of the patient's records may be accessible through the patient portal and/or the Health Information Exchange. Patient acknowledges and agrees the patient's records will be available to all Langley Health Services affiliated entities and providers, and to non-Langley affiliated providers in compliance with the provisions of meaningful use.

Patient Rights, Responsibilities and Information and Patient Centered Medical Home

I choose to participate in the Patient-Centered Medical Home. These documents are posted in the lobby and on our website: www.langleymedicalcenter.com. I acknowledge that I have received or have been allowed to view a copy of each and understand and agree to the terms set forth in the policies.

After Hours Non-Emergency Services

Patients have after-hour access to on-call Langley Health Services providers 24 hours a day, seven days a week through an answering service by calling (352) 793-5900. For medication refills, please contact your pharmacy or Langley Health Services during normal business hours. For emergency services, call 911 or go to the nearest hospital emergency room.

Residents, Students and Observers

I understand that Project Health, Inc. d/b/a Langley Health Services (LHS) supports the education of medical professionals and maintains Students that may assist in relation to care. I understand that in accordance with LHS federal regulations & accreditation, as well as educational training, residents, students and observers may be present in patient care areas.

Appointment No-show Policy

If you are unable to attend your appointment with a provider, it is expected that you will contact the office in advance to ensure you are rescheduled. If you fail to contact the office prior to your appointment, your missed appointment will be considered a "no-show." If you have three or more "no-shows" within a 3-month period, you will be notified that you are now on a waitlist to be seen by a LHS provider. You will be contacted for an appointment as availability opens from the waitlist. In the event that you need urgent care, same-day appointments are available throughout LHS locations for medical and/or dental needs.

Notice of Policy Regarding Advanced Directives ***only for patients over 18 years of age***

Advanced Directives are legal statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make decisions as well as who is authorized to make those decisions for them. Advance directives are made and witnessed prior to the occurrence of any serious injury, possible life threatening event, or certain surgical procedures.

In accordance with federal and state law, this serves as notification that we will set aside your advance directive in the event you experience a life threatening event while at one of the Langley Health Services locations and you will be transferred to a higher level of care.

By signing below, you agree and understand this as notification. Please indicate below whether or not you have an advanced directive or if you would like to receive information on advance directives.

☐ I have an advanced directive.
☐ I do not have an advanced directive.
☐ I would like to receive information on advanced directives.

Consent for Use and Disclosure of Protected Health Information (PHI)

Project Health, Inc. d/b/a Langley Health Services (LHS) is committed to ensuring the privacy and confidentiality of your medical information. To assist us in protecting your privacy, please complete the following information:

(Check Yes or No)	Yes	No
May we leave a clinical message if no answer?		
May we leave a billing concern message if no answer?		
May we send an appointment reminder using text messaging? *If yes, what is your cell phone carrier?* _____		
May we send you an email regarding reminders and clinical notes?		

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, appointments, etc? ◯ Yes (If yes, please list the name(s) in the space(s) below) ◯ No

Name	Relationship	Phone Number

**You have the right to revoke whom we talk with about your health care at anytime. Please complete a new consent.

Assignment of Medicare Benefit ***only for patients covered by Medicare***

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare and request payment of medical insurance benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original, as long as I receive services at LHS. I understand that I am responsible for my co-insurance amount on Medicare coverable services. I further understand that the Part B deductible does not apply to FQHC services; however, should I receive services that are non-covered under FQHC, I will be responsible for the part B deductible. I have completed a copy of the Medicare Secondary Payor (MSP) Questionnaire.

I understand I may revoke this consent in writing at any time. When the consent is revoked it will only affect my health information from that point on.

By signing below, I verify this information to be true to the best of my ability. Additionally, I agree, understand, and consent to all items in the Consents and Acknowledgements section.

REQUIRED SIGNATURES	
Signature of Patient/Guardian:	Today's Date:
Signature of Langley Health Services' Employee:	Today's Date:

Informed Consent for Dental Procedures

Patient Name: _____ Patient Date of Birth: _____

All patients complete 1 through 4 below

PROCEDURE	INITIALS TO CONSENT
1. EXAMINATIONS AND X-RAYS I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand a detailed treatment plan will be given. I hereby give consent and authorize examination and treatment at Project Health, Inc. d/b/a Langley Health Services (LHS) by the personnel at LHS. The need for the examination and treatment, and the possibility of undesirable side effects, will be explained by the employees of LHS. I understand there is no guarantee or assurance, as to the results which may be obtained, but normal prudent care will be exercised by employees or LHS concerning my diagnosis and treatment. Informed Consent for Dental Procedures will be obtained.	
2. DRUGS AND MEDICATION I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions resulting in redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of all known allergies and all medications I am currently taking.	
3. CHANGES IN TREATMENT PLAN I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were undetectable during examination. Any change in the plan will be explained immediately and a new consent will be signed if necessary. The most common change in treatment plan being the discovery of the need for root canal therapy during or following restorative procedures.	
4. TEMPOROMANDIBULAR JOINT DYSFUNCTION I understand that popping, clicking, locking and pain can intensify or develop in the joints (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise I will be referred to a specialist for treatment, the cost of which is my responsibility.	

ADULT MEDICAL/DENTAL HISTORY- please give this page to your clinical staff team member

Patient Name:	Date of Birth:	Today's Date:
Primary Care Provider's Name:		Provider's Phone #:
Date of last primary care exam:		
List of current medications:		

MEDICAL HISTORY (do you currently have or have you had any of the following? If yes, please check the box)			
ADD/ADHD		Diabetes	
Psychiatric/mental disorders		High Blood pressure	
Addictions		Low Blood pressure	
Heart disease		Ulcer/reflux	
Congenital Heart Defects		Hepatitis/jaundice	
Heart murmur		Anemia	
Heart attack		Sickle cell anemia	
Cardiac pacemaker		Leukemia	
Mitral Valve Prolapse		Cancer	
Artificial Heart Valve		Kidney disease	
Chest pains		Thyroid problems	
Lung conditions: asthma, emphysema		Hemophilia	
Easily winded		Liver disease	
Fainting/seizures/epilepsy		Communicable diseases	
Prolonged bleeding		Sexually Transmitted Diseases	
Radiation treatment		AIDS, ARC, HIV	
Artificial joint/joint replacement		Arthritis	
Stroke		Other:	

ALLERGIES (list all known)
ORAL SURGERIES (list all known)
HOSPITALIZATIONS

FOR WOMEN ONLY	
Are you currently or trying to become pregnant?	◯ YES ◯ NO
Are you currently nursing?	◯ YES ◯ NO
Are you currently taking birth control?	◯ YES ◯ NO

RISK FACTORS			
Tobacco use?	◯ Current	◯ Former	◯ Never
Drug use?	◯ Current	◯ Former	◯ Never
Alcohol use?	◯ Current	◯ Former	◯ Never

DENTAL HISTORY			
Date of last dental visit:			
How often do you floss? ◯ Never ◯ Sometimes ◯ Often			
How often do you brush? ◯ Never ◯ Sometimes ◯ Often			
Do you currently have or have you had any of the following? Please check YES or NO			
Sensitive teeth	◯ YES ◯ NO	Painful teeth	◯ YES ◯ NO
Clenching/grinding	◯ YES ◯ NO	Frequent headaches	◯ YES ◯ NO
Jaw or facial pain	◯ YES ◯ NO	Dental Implants	◯ YES ◯ NO
History of orthodontic treatment (i.e.- braces, Invisalign, etc.)			◯ YES ◯ NO

Patient Signature:	Provider Signature:

Revised 11/14/2023

The following pages are for your (the patient's) review. You do not need to turn them in with your packet.

Patient's Bill of Rights and Responsibilities

PATIENT RIGHTS

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know that rules and regulations apply to his or her conduct.
- A patient has the right to know to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to pain relief.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to provide feedback, whether negative or positive, regarding the service that was received.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate licensing agency.
- A patient has the right to change providers if other qualified providers are available.
- A patient has a right to have his or her prescriptions filled at their pharmacy of choice.
- A patient has the right to information and an explanation regarding the Patient Centered Medical Home approach to care.
- A patient has the right to obtain information and forms related to Advanced Directives (living will and health care surrogate designation).

PATIENT RESPONSIBILITIES

- A patient is responsible for providing complete and accurate information to the best of their ability about their health to the health care provider. Information will include any medications taken, including over-the-counter products and dietary supplements, allergies, sensitivities, present complaints, past illnesses, hospitalizations, and other matters relating to his or her care.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the agreed-upon treatment plan prescribed by the health care provider and participate in their care.
- A patient is responsible to provide a responsible adult to provide transportation home and to remain with patient as directed by the provider or as indicated on discharge instructions.
- A patient is responsible for keeping appointments and, when unable to do so for any reason, for notifying the healthcare provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatments or does not follow the provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for the need to accept personal financial responsibility for any charges not covered by insurance.
- A patient is responsible for following health care facility rules and regulations affecting patient care and to behave respectfully toward all health care professionals and staff, as well as other patients and visitors.
- If participating in the Patient Centered Medical Home, a patient is responsible for talking with his/her team about health questions, sharing past health care successes and challenges, telling the team about other health care professionals that care for him/her, following the health care plan that has been discussed, making sure he/she understands the plan and asks questions if not understanding, telling the team if you are having trouble sticking with the care plan, and speaking up if the care plan is not working so together changes can be made, if needed.

Notice of Privacy Practices
Effective September 30, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

- **For Care or Treatment**: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*
- **For Payment:** Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*
- **For Business Operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*
- **Required by Law:** Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.
- **Without Authorization**: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:
    - Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
    - Required by Court Order
    - Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Verbal Permission:** We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.
- **With Authorization**: Uses and disclosures not specifically permitted by applicable law will be made ***only with your written authorization***, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.
- **Your rights regarding your PHI**
- You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:
    - **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
    - **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.

- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *LHS.* If you have questions and would like additional information, you may contact us at (352) 793-5900 or toll free at (888) 298-5510.