JOSEPH M. CATALANO, D.D.S., P.C.
Oral Surgery and Implantology

Welcome

We are pleased that you have selected our practice to provide treatment for your current medical and dental needs. Thank you for allowing us to participate in your health care!

Due to COVID-19 we ask you be aware of your surroundings in our office and maintain social distancing along with wearing a mask at all times. If you notice that the waiting room has too many patients to create a 6 foot distance between those not of the same household, please advise the front desk. We are sanitizing all clip boards and pens after each and every patient. Please be courteous of others. Thank you in playing your part in helping prevent the spread of COVID-19!

A consultation/exam fee is charged for you first visit, which may include:

- Oral examination
- Review of medical history
- Diagnosis (clinical and radiographic)
- Surgical and anesthesia options
- Discussion of what to expect during the postoperative recuperation period
- Discussion of risks and complications associated with treatment or non-treatment

Fees for consultation and X-Rays/3-D Scans are billed to your dental insurance. If you do not have dental insurance, these fees are due at the time of service. We will collect for X-Ray and office visit upon check out. Dr. Catalano does offer a reasonable, discounted self-pay rate for those without insurance coverage. We accept all major credit cards including the Care Credit card subject to a 2% courtesy fee on all transactions. We also accept personal checks up to $500 and cash.

An insurance company's authorization for consultation and X-rays does not guarantee their payment. Ultimately, you, as the patient are responsible for your insurance and any uncovered charges. If there is a question with your coverage, please feel free to verify your coverage with your provider prior to consultation.

As a courtesy to our patients we do offer when possible, custom estimates for procedures, should you be interested. We will gather your dental insurance benefits for your specific oral surgery needs and create a custom treatment plan which will provide you with your estimated patient portion for your procedure. We will do our best to create your estimate while you are here for your consultation time permitted, otherwise please be prepared to share with us your email address so we can email you the estimate at a later date, yet still before your scheduled procedure.

Please sign and date below to acknowledge that you have read and agree to the above terms.

Patient/Guardian Signature: _____ **Date:** _____

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PATIENT REGISTRATION

DATE:_____ NAME OF GENERAL DENTIST:_____ REFERRED BY:_____

NAME:_____
FIRST NAME INITIAL LAST NAME

MAILING ADDRESS:_____ UNIT #:_____

CITY:_____ STATE:_____ ZIP:_____

PRIMARY PHONE NUMBER:_____ ❑ HOME ❑ CELL EMAIL:_____

SEX: ❑ MALE ❑ FEMALE AGE:_____ BIRTH DATE:_____ ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ SEPARATED ❑ DIVORCED

PERSON RESPONSIBLE FOR ACCOUNT:_____ CELL PHONE:_____
FIRST NAME INITIAL LAST NAME

RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ OTHER _____ BIRTH DATE:_____ SOC. SEC #:_____

EMPLOYED BY:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____ WORK PHONE:_____

PRIMARY INSURANCE **(DENTAL)**

INSURANCE COMPANY:_____

MEMBER ID:_____ **GROUP #:**_____

CLAIMS ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

POLICYHOLDER:_____
(PRIMARY INSURED) **FIRST NAME** **LAST NAME**

BIRTH DATE:_____ **SOC. SEC. #:**_____

MAILING ADDRESS (IF DIFFERENT FROM PATIENTS):_____

CITY:_____ **STATE:**_____ **ZIP:**_____

SECONDARY INSURANCE **(DENTAL)**

INSURANCE COMPANY:_____

MEMBER ID:_____ **GROUP #:**_____

CLAIMS ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

POLICYHOLDER:_____
(PRIMARY INSURED) **FIRST NAME** **LAST NAME**

BIRTH DATE:_____ **SOC. SEC. #:**_____

MAILING ADDRESS (IF DIFFERENT FROM PATIENTS):_____

CITY:_____ **STATE:**_____ **ZIP:**_____

PRIMARY INSURANCE **(MEDICAL)**

INSURANCE COMPANY:_____

MEMBER ID:_____ **GROUP #:**_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

POLICY HOLDER:_____ **BIRTH DATE:**_____ **SOC. SEC. #:**_____
(PRIMARY INSURED) **FIRST NAME** **LAST NAME**

MAILING ADDRESS (IF DIFFERENT FROM PATIENTS):_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

PHARMACY NAME:_____ PHARMACY PHONE #:_____

ASSIGNMENT and RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the following Insurance Company(ies): _____, and assign directly to Joseph M. Catalano, D.D.S., P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that interest of 18% per year (1.5% per month)will be charged monthly on outstanding balances of all accounts that are delinquent and that each additional monthly statement will incur a $5.00 billing fee. I understand that I am responsible for any collection cost or attorney fees incurred in collecting a delinquent account as defined above.

X_____ _____ _____
SIGNATURE OF PATIENT OR AUTHORIZED GUARDIAN RELATIONSHIP DATE

JOSEPH M. CATALANO, D.D.S., P.C.

Oral Surgery and Implantology

Health History

Patient's Name:_____ **Date:** _____

Patient's Date of Birth: _____ **Height:** _____ **Weight (pounds):** _____

Please circle yes or no, whichever applies. Your answers are for our record only and will be confidential. Please make sure that everything is filled out completely.

1. Have there been any changes in your general health in the last year?.....**Yes/No**

2. When was your last physical exam?_____ **PCP:**_____ **Ph.#:**_____

3. Are you now under the care of a physician?.....**Yes/No**

If so, what is the condition being treated? _____

4. Have you had any serious illness requiring hospitalization? .....**Yes/No**

5. Please list past surgical history:_____

6. Have you had any serious problems associated with general anesthesia or sedation?.....**Yes/No**

If so please explain:_____

7. Have you had any problems associated with previous dental treatment? .....**Yes/No**

If so, please explain:_____

8. Does your jaw joint (TMJ) pop click, lock, or cause pain? .....**Yes/No**

9. Do you have any of the following diseases or problems?

- **a.** Heart Murmur or Rheumatic Heart Disease.....**Yes/No**
- **b.** Heart Valve Replacement.....**Yes/No**
- **c.** Do you have Prosthetic or Artificial Joints.....**Yes/No**
- **d.** History or current Cardiovascular Disease (heart attack, heart "event", coronary occlusion, angina, stroke).....**Yes/No**
- **e.** High Blood Pressure or Hypertension.....**Yes/No**
- **f.** Asthma, Bronchitis, TB, or Emphysema.....**Yes/No**
- **g.** Fainting Spells or Seizures.....**Yes/No**
- **h.** Diabetes.....**Yes/No**
- **i.** Hepatitis, Jaundice, or Liver disease.....**Yes/No**
- **j.** Bleeding disorders, prolonged bleeding, difficulty clotting or easy bruising.....**Yes/No**
- **k.** HIV.....**Yes/No**
- **l.** Arthritis or Rheumatism.....**Yes/No**
- **m.** Stomach Ulcers.....**Yes/No**
- **n.** Kidney Problems.....**Yes/No**
- **o.** Do you have any disease, condition, or problems not listed that you think Dr. Catalano should know about? If so, please explain:

_____

10. Do you smoke or use other tobacco products?.....**Yes/No**

11. Are you allergic to or have reacted adversely to any drug or latex? (rash, itching, swelling or difficulty breathing).....Yes/No

Drug Allergies: _____

12. Are you currently taking any prescription or over the counter medicine/supplements?.....**Yes/No**

Please List Your Current Medications: (both over the counter and prescription) in the table below:

Prescription Name	Condition RX Treats	Dosage Qty. (per day)	Dosage Amount (MG etc.)	Notes

13. Have you been diagnosed or tested for COVID-19? _____
If so, when and with what results: _____

14. Are you now, or have you ever been treated with oral or intravenous **Bisphosphonates** for Osteoporosis/ Osteopenia/Arthritis/Cancer Bone Metastases?.....**Yes/No**
- <u>Oral forms:</u> (Fosamax, Actonel, Skelid, Didronel, and Boniva.)**<u>Intravenous forms:</u>** (Zometa/Aredia)
- Failure of disclosure can lead to complications in healing (osteonecrosis of the jaw)

Please read and initial the following statements:

_____ **Drug or Alcohol Abuse:**
Do you have a history of social drug use.....**Yes / No**
Recreational drug use, overdose with medication, or excessive alcohol consumption can adversely affect the liver function which is critical for producing blood clotting factors. Disclosure will allow your surgeon to safely treat you and prevent excessive post-surgical bleeding that can be life-threatening.
Current Recreational Drug Use: Interaction with local anesthesia and IV sedation agents can be life threatening. Full disclosure is critical for safe management.

Women Only

_____ Are you pregnant, or think there is a chance you may be pregnant?.....**Yes / No**
Pregnancy: I understand that if there is a possibility of current pregnancy, I will complete a home pregnancy test prior to scheduling an IV Sedation/general anesthetic procedure and report the results to my treating surgeon. Medications used during the surgery and post-operative period can adversely affect a developing baby.

_____ Do you have any problem/s associated with your menstrual cycle?.....**Yes / No**

_____ Are you on birth control medication?.....**Yes / No**
Birth Control Pills: Antibiotics are commonly prescribed during your surgical management. Antibiotics can decrease the efficacy of birth control pill leading to pregnancy. It is recommended that a second alternative form of birth control be used for one full cycle (month) if pregnancy is not desired.

The above history is true to the best of my knowledge.

Patient/Guardian Signature:_____ **Date:**_____

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MEMBER AAOMS

HIPAA
Notice of Privacy Practices

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

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes: A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such a specialist and obtain input.

Example of uses of your health information for payment purposes: We submit a request for payment to your health/dental insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given along with any corresponding treatment notes and/or X-rays or 3-D scans.

Example of uses for your health information for health care operations: We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights:

The health record we maintain and billing records are the physical property of the practice. The information in it, however belongs to you. You have rights to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request, however we will comply with any request granted.
- Request that you be allowed to inspect and copy your health record and billing record, you may exercise this right by delivering the request in writing to our office
- Appeal a denial of access to your protected health information except in certain circumstances
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office and revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact the HIPAA Privacy Officer at (303)-768-8222 during normal business hours. You may also contact her in person or in writing at:

10103 Ridgegate Parkway Suite #214 Lone Tree, CO 80124. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities-The practice is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we cannot accommodate a requested restriction of request
- Accommodate your reasonable requests regarding methods to communicate health information with you

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our notice. You are entitled to receive a revised copy of the notice by calling and requesting a copy of our notice or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the HIPAA Privacy Officer at (303)-768-8222

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the HIPAA privacy officer. You may also file a complaint by mailing or emailing it to the secretary of health and human services whose street address and email address are available upon request.

- We cannot and will not require you to waive your right to file a complaint with the secretary of health and human services as a condition of receiving treatment from the practice.
- We cannot and will not retaliate against you for filing a complaint with the secretary.

Other Disclosures and Uses

Notification: Unless you object, we may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, about your location and about your general condition, or your death.

Communication with Family: Using our best judgement, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacements.

Workers Compensation: If you are inmate of a correctional institution, we may disclose to the institution, or its agents your protected health history necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight: Federal law allow us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding s as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses: Other uses and disclosures besides those identified in this notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website: If we maintain a website that provides information about our entity, this notice will be on the website.

I, _____ herby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

Patient/Guardian Signature: _____ **Date:** _____

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Procedure Cancellation Policy

Please understand that your surgery appointment is not a routine office visit and the following cancellation policy will apply:

A 10% fee ($200 minimum) of the estimated charges will be assessed if:

- You do not follow all of your pre-operative instructions given
- You do not provide a minimum of 48 business hours' notice to cancel your procedure
- You "no show" for your procedure
- You are more than 10 minutes late for your procedure check in time
- Estimated patient portion has not been paid in full at the time of check in

Please note that if you cancel your procedure without following these cancellation policy requests, you will need to be pay your cancellation fee in full *prior* to re-scheduling your procedure.

Cancellations must be made during our normal business hours of:

Monday: 11:00am-3:00pm
Tuesday: 9:00am-5:00pm w/lunch from 1:00pm-2:00pm
Wednesday: 9:00am-5:00pm w/lunch from 1:00pm-2:00pm
Thursday: 9:00am-5:00pm w/lunch from 1:00pm-2:00pm
Friday: 8:30am-2:00pm

We do **not** accept cancellations via email or our answering service. Thank you for your considerateness of our office team as well as other patients.

Patient/Guardian Signature: _____ **Date:** _____