BREI

ROBERT C. BREI, DDS

COSMETIC AND FAMILY DENTISTRY

We are delighted to welcome you to our practice!

Your comprehensive evaluation will take approximately 1 hour. Please arrive 15 minutes early.

To facilitate our registration data entry our office would appreciate it if you would complete the enclosed Patient Information Form before your arrival. Please remember to bring it with you or mail the completed form back to us as soon as possible. We have enclosed a self-addressed envelope for your convenience. We have not included forms with this letter if when scheduling your appointment you indicated that you would fill them out or download forms from our website:
http://drbrei.com/resources-patient-forms-2

If you are unable to make the appointment you have scheduled with us, please notify us at least 48 hours in advance to avoid a cancelation charge. We would be glad to reschedule the appointment at a more convenient time, if necessary. In the meantime, we look forward to meeting you and serving your needs.

Please bring the information marked below with you or prior to your appointment:

___ *New Patient Paperwork*
___ *X-rays from previous office requested by you*
___ *Medication List*
___ *Insurance Card*
___ *Appointment Change Policy*
___ *Allergy List/Medical Alerts*

Thanks again for choosing our dental practice.
Sincerely,

ROBERT BREI, DDS

(520) 325-9000 | office@drbrei.com | www.drbrei.com | 4820 E. Camp Lowell Dr. Tucson, Az. 85718

ROBERT C. BREI, DDS

COSMETIC AND FAMILY DENTISTRY

NO SHOW / CANCELLATION POLICY

Effective Jan 1, 2013

Patient Name:

A No Show fee will be charged to your account if:

- You do not show up for you scheduled appointment or
- You do not cancel your scheduled appointment at least 24 hours prior to your scheduled appointment time.

This includes all established appointments, dental procedures, dental cleanings and cosmetic appointments. The fees are as follows:

- **1st missed appointment:** If an appointment is missed or canceled within the 24 hour window, a letter will be sent to your home reminding you of our policy. We reserve the right to charge you $50 for each hour appointment time scheduled.
- **2nd missed appointment:** After your second missed appointment, another letter will be sent to your home notifying you, of a $50 charge to your account. In order for you to make another appointment this charge must be paid.
- **3rd missed appointment:** Will be charged the full appointment fee and or dismissal from our practice.

Our office understands that true emergencies do happen. If this is the case, please provide us with adequate reasons or proof and the missed appointment will be removed from your accounts record.

LATE ARRIVAL: When we reserve time for you, we require all of the scheduled time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. Please try to arrive on time so that we are not late for our remaining appointments of the day.

I have read the policy above. I understand and agree to abide by the listed terms.

_____

PATIENT SIGNATURE (of Guarantor if under 18 years of age)

Robert Brei, DDS(520) 325-9000 | office@drbrei.com | www.drbrei.com | 4820 E. Camp Lowell Dr.Tucson, Az. 85718

BREI

ROBERT C. BREI, DDS

COSMETIC AND FAMILY DENTISTRY

PERSONAL INFORMATION CONSENT

Patient Name: _____ Phone Number: _____ Email: _____

The office of Robert Brei may leave or disclose the following health care information on my answering machine or cell phone IF I am not available to take the call (Check all that apply):

- ☐ Appointment Information
- ☐ Health Information
- ☐ Premedication refills and reminders
- ☐ Financial Information
- ☐ ALL of the above
- ☐ I do not want any health information left on my answering machine.

Please indicate person(s) authorized to receive information.

Name(s)	Phone Number	Relationship

I understand that I do not have to sign this authorization in order to get healthcare benefits. Additionally, I understand that I may revoke this authorization in writing to:

ROBERT C. BREI, DDS
4820 E. CAMP LOWELL DR.
TUCSON, AZ. 85712-1276

I understand that if this office requested this authorization, I have the right to receive a copy of it.

Patient/Representative: _____ Date: _____

Printed Name if signed by representative: _____ Relationship: _____

Staff Member _____ Date: _____

Welcome to our office!

EMAIL:

NEW Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender_____ Family Status: _____

Social Security_____ Birth Date_____

Phone (Home): _____ (Work): _____ Ext _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Who may we THANK for referring you to our office: _____

Health Information

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

Medical Alerts:

	YES	NO		YES	NO		YES	NO
AIDS	☐	☐	**Glaucoma**	☐	☐	**Pregnant** Due Date:_____	☐	☐
Anemia	☐	☐	**Head Injuries**	☐	☐	**Psychiatric Care**	☐	☐
Angina or Chest Pain	☐	☐	**Heart Disease or Surgery/Pace Maker**	☐	☐	**Radiation Treatment**	☐	☐
Arthritis	☐	☐	**Heart Murmur/Cond.**	☐	☐	**Respiratory Problems**	☐	☐
Asthma	☐	☐	**Hepatitis**	☐	☐	**Rheumatism**	☐	☐
Blood Disease	☐	☐	**Herpes**	☐	☐	**Seizures**	☐	☐
Bruise Easily	☐	☐	**High Blood Pressure**	☐	☐	**Sinus Problems**	☐	☐
Cancer	☐	☐	**Joint Replacement**	☐	☐	**Stomach Problems**	☐	☐
Chemotherapy	☐	☐	**Kidney Disease**	☐	☐	**Stroke**	☐	☐
Cortisone Meds	☐	☐	**Liver Disease**	☐	☐	**Thyroid Disease**	☐	☐
Diabetes	☐	☐	**Lung Disease**	☐	☐	**TMJ - Ortho**	☐	☐
Drug Addiction	☐	☐	**Nervous Disorders**	☐	☐	**Tuberculosis**	☐	☐
Emphysema	☐	☐	**Pacemaker**	☐	☐	**Venereal Disease**	☐	☐
Epilepsy	☐	☐	**Osteoporosis/Fosamax**	☐	☐	**OTHER:**	☐	☐
Excessive Bleeding	☐	☐				_____	☐	☐
Fainting or Seizures	☐	☐	**LIST MEDICATIONS:**			_____	☐	☐
ALLERGIES:			☐ _____					
☐ **Codeine Allergy**			☐ _____					
☐ **Latex Allergy**			☐ _____					
☐ **Penicillin Allergy**			☐ _____					
☐ _____			☐ _____					

- **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, please explain:**
  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.

_____ **Date:** _____
Signature of patient, parent or guardian

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

We are a premier provider for Delta Dental
and
We accept any insurance that allows you to go to the doctor of your choice.
If your insurance offers an "*In network*" verses *"out of network"* option, we will be considered *"out of network"*.

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____ Occupation: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient's account and that he or she is personally responsible for payment of all dental services not covered by the insurance company. This office will help prepare the patients insurance form or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patients are required to pay their estimated portion of the services rendered at the time of service.

A service charge of 1 ½ per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient's examination and is subject to insurance benefits.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall by as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of anytime or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand that I will be charged a $50.00 ***"Broken Appointment Fee"*** if I fail to keep an appointment or if I do not give at least 24 hours notice when canceling an appointment except in the case of an emergency.

I grant my permission to you or your assignee, to telephone me at home, at my work, or my cell phone to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

_____ _____ _____

Signature of patient, parent or guardian Date Relationship to patient

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013, and will remain in effect until we replace it.

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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request. You may request a copy of our Notice at any time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and examples. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: To provide, coordinate, or manage your health care. The following methods, fax, mail or email will be utilized to communicate your information to health care providers or establishments.
Payment: To obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party.
Healthcare Operations: Health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.
Individuals Involved in Your Care or Payment: Disclose your health information to your family, friends or any other individual identified by you. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.
Public Health Activities: To public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
- Risk or contracting or spreading a communicable disease or condition.

National Security: 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 institution or law enforcement official having lawful custody the protected health information of an inmate or patient.
Secretary of HHS: To the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.
Disaster Relief: To assist in disaster relief efforts.
Worker's Compensation: To the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Required by Law: When required by federal or state law.
Law Enforcement: To law enforcement authorities.
Health Oversight Activities: To an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Judicial and Administrative Proceedings: To parties and entities in proceeding of the courts and administrative agencies, including in response to a court order or subpoena.
Research: To researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Coroners, Medical Examiners, and Funeral Directors: To a coroner or medical examiner. For example, to identify a deceased person, determine the cause of death and to funeral directors consistent with applicable law to enable them to carry out their duties.

Other Uses and Disclosures of PHI: Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights
Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.
Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
Right to Request a Restriction: To request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
Alternative Communication: To request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
Amendment: 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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints
If you are concerned that we may have violated your privacy rights, or if 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 or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

- **My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act (HIPAA), 2013 Final Rule.**

  This is to advice you that our office is in compliance with this federally mandated Notice of Privacy Practices law.

Patient Name: **Date:**

Signature:_____ Relationship to Patient: _____

Our Privacy Official:
Robert Brei, DDS
4820 E. Camp Lowell Dr., Tucson,Az 85712
P: 520-325-9000 F: 520-881-3601
office@drbrei.com