PATIENT INFORMATION

*(This information is necessary for our files and will be considered **CONFIDENTIAL**)*

Date _____

Patient's Name _____ (LAST / FIRST / INITIAL) Age ____ Patient's Birthday _____ ❑ Male ❑ Female

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ (STREET / CITY / ZIP) For how long? _____ ❑ Own ❑ Rent

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor E-mail _____

Driver's License No. _____ Social Security No. _____ Res. Phone ( ) _____

Pharmacy

_____ How long? _____ Cell Phone ( ) _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. _____

Employed by _____ How long? Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ (STREET / CITY / ZIP) Res. Phone ( ) _____

❑ I have no physician

Name of Physician _____ (ADDRESS / CITY) ( ) _____ (TELEPHONE)

Former Dentist _____ (ADDRESS / CITY) ( ) _____ (TELEPHONE)

Why are you changing dentists? _____

Purpose of Appointment _____ Do you wish to speak to the doctor privately? ❑ Yes ❑ No

Is this office visit for Emergency Dental Care? ❑ Yes ❑ No If yes, explain: _____

School Children Attend _____ Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____ ( ) _____ (TELEPHONE)

Address _____ (STREET / CITY / ZIP) ( ) _____ (CELL PHONE)

PREFERENCE OF PAYMENT: ❑ Cash on day of treatment ❑ Visa No. _____ (EXPIRATION DATE)

❑ State Aid No. _____ ❑ Mastercard No. _____ (EXPIRATION DATE)

Name of insurance company (primary insurance) _____

INSURED PERSON'S NAME / BIRTHDATE / RELATIONSHIP / SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL

Name of insurance company (secondary insurance) _____

INSURED PERSON'S NAME / BIRTHDATE / RELATIONSHIP / SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

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

I have read the above conditions of treatment and agree to their content:

Signed _____ Date _____

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? ..... (Yes) No

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination _____
3. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation? _____
5. Have you ever been hospitalized? ..... Yes No
   If so, what was the problem? _____
6. Are you taking any ❑ medications, ❑ drugs or ❑ herbs? ..... Yes No
   If so, what? _____ What dosage? _____
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ❑ Yes ❑ No If so, what? _____
8. Have you ever been pre medicated with antibiotics for your dental treatment? ..... Yes No
9. Are you sensitive or allergic to any drugs or materials? ❑ Penicillin; ❑ Tetracycline; ❑ Sulfa Drugs; ❑ Aspirin; ❑ Codeine; ❑ Latex; ❑ Other ..... Yes No
   If Other, what drugs? _____
10. Do you have or have you had any of the following: (Please circle '**Y**' for Yes or '**N**' for No - answer all conditions):

Y N Anemia	Y N Glaucoma	Y N Sleep Apnea	Y N Angina Pectoris	Y N Pain in Jaw Joints	Y N Psychiatric Treatment	Y N Other
Y N Herpes	Y N Tonsillitis	Y N Snoring	Y N Mental Disorder	Y N Artificial Prosthesis	Y N Hepatitis or Jaundice	
Y N Stroke	Y N Hemophilia	Y N Heart Murmur	Y N Thyroid Disease	Y N Sickle Cell Disease	Y N Difficulty Swallowing	
Y N Ulcers	Y N Cold Sores	Y N Liver Disease	Y N Fainting Spells	Y N Cortisone Medicine	Y N Congenital Heart Lesions	
Y N Diabetes	Y N Emphysema	Y N Blood Disease	Y N Rheumatic Fever	Y N Allergies to Metals	Y N Osteoporosis	
Y N Arthritis	Y N Rheumatism	Y N Heart Ailments	Y N Tuberculosis (T.B.)	Y N Excessive Bleeding	Y N X-Ray or Cobalt Treatment	
Y N Asthma	Y N Chicken Pox	Y N Heart Attack	Y N Blood Transfusion	Y N Mitral Valve Prolapse	Y N Radiation Treatment of any kind	
Y N Cancer	Y N Bruise Easily	Y N Cerebral Palsy	Y N Low Blood Sugar	Y N High Blood Pressure	Y N Venereal Disease (Syphilis, Gonorrhea)	
Y N Seizures	Y N Head Injuries	Y N Drug Addiction	Y N Joint Replacement	Y N Low Blood Pressure	Y N Acquired Immune Deficiency Syndrome (AIDS)	
Y N Hay Fever	Y N Heart Failure	Y N Kidney Disease	Y N Nervous Disorders	Y N HIV Related Complex	Y N TMJ (Temporomandibular Joint) Disorder	
Y N Headaches	Y N Scarlet Fever	Y N Chemotherapy	Y N Tumors or Growths	Y N Respiratory Disease		
Y N Implant (s)	Y N Sinus Trouble	Y N Stomach Ulcers	Y N Allergies or Hives	Y N Epilepsy or Seizures		

11. Do you have any disease, condition or problem not listed that you think we should know about? ..... Yes No
    If so, what? _____
12. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... Yes No
13. Do you smoke? If yes, how much? _____ ❑ Cigarettes ❑ Cigars ❑ Packs per day ..... Yes No
14. Have you ever taken the drugs ❑ Fen-Phen, ❑ Redux, ❑ Fosamax (Bisphosphonate), ❑ Zometa, ❑ Actonel, ❑ Boniva, ❑ Aredia, ❑ Diet Drugs? ..... Yes No
15. (Women) Are you pregnant? If so how many months? _____ Yes No
16. (Women) Do you have any problems associated with your menstrual period? Yes No
17. (Women) Do you take any birth control medication or hormones? ..... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ..... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain? _____
4. How long since your last full mouth X-Rays? _____ Weeks _____ Months _____ Years
5. How long since your last dental treatment? _____ Weeks _____ Months _____ Years
6. Does dental treatment make you nervous? ❑ Slightly ❑ Moderately ❑ Extremely? ..... Yes No
7. Would you desire to be pre-sedated? ..... Yes No

❑ I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way. ❑ Patient refused / was unable to sign because _____.

❑ I have received a copy of the **Dental Materials Fact Sheet** as required by law.

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

A **Date** _____ **Signature** _____

Reviewed by _____ Lic. # _____ Date _____

B ***UPDATE — Since your last visit A:***

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in your medication? ..... Yes No
3. Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date _____ **Signature** _____

C ***UPDATE — Since your last visit B:***

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in your medication? ..... Yes No
3. Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date _____ **Signature** _____

REVIEWED BY	DO NOT WRITE IN THIS SPACE			
A		A	B	C
DATE	DATE			
B	B.P.	/	/	/
DATE	PULSE			
C	TEMP			
DATE	BY			

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: _____ **Date:** _____ **Relationship to Patient** _____

126 West Deodar Avenue
Oxnard, California 93030
(805) 983-0717

Derek Kleker Carson, D.D.S. Inc.
LeRoy Kleker Carson, D.D.S.

70 Daily Drive
Camarillo, California 93010
(805) 987-1711

Patient Questionnaire

Patient Name _____ SS# _____ Occupation: _____

Reason for Visiting _____

Please answer all questions by marking YES or NO. Your response to this questionnaire will be held strictly confidential and will only be used to assist in the assessment of your medical condition. If you have any hesitations please discuss you concern with the doctor.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Cardiovascular Disorders:

YES NO

- ❑ ❑ High blood pressure
- ❑ ❑ Congenital heart disease
- ❑ ❑ Rheumatic fever
- ❑ ❑ Heart murmur
- ❑ ❑ Heart pacemaker
- ❑ ❑ Vascular graft
- ❑ ❑ Heart or bypass surgery
- ❑ ❑ Artificial heart valve
- ❑ ❑ Heart attack
- ❑ ❑ Congestive heart failure
- ❑ ❑ Awaken with breathing difficulty
- ❑ ❑ Angina pectoris/chest pain
- ❑ ❑ Swollen ankles
- ❑ ❑ Irregular or rapid heart beats
- ❑ ❑ Stroke

Respiratory Disorders

YES NO

- ❑ ❑ Emphysema or asthma
- ❑ ❑ Hay fever
- ❑ ❑ Chronic cough or bronchitis
- ❑ ❑ Tuberculosis (TB)
- ❑ ❑ Chronic sinusitis
- ❑ ❑ Breathing problems

Musculo-Skeletal/CNS/ Developmental Disorders:

YES NO

- ❑ ❑ Frequent headaches
- ❑ ❑ Fainting spells or loss of consciousness
- ❑ ❑ Seizures or Epilepsy
- ❑ ❑ Visual impairment
- ❑ ❑ Hearing impairment
- ❑ ❑ Artificial joint
- ❑ ❑ Arthritis or bone disease
- ❑ ❑ Muscle disease
- ❑ ❑ Spinal cord injury or paralysis
- ❑ ❑ Cerebral palsy
- ❑ ❑ Mental retardation/autism
- ❑ ❑ Alzheimer's disease or other dementia

Gastrointestinal/Genitourinary Disorders

YES NO

- ❑ ❑ Colitis or ulcers
- ❑ ❑ Hepatitis or other liver disease
- ❑ ❑ Jaundice
- ❑ ❑ Renal dialysis/transplant
- ❑ ❑ Kidney disease
- ❑ ❑ Syphilis, Gonorrhea or other sexually transmitted diseases
- ❑ ❑ Genital herpes
- ❑ ❑ Frequent canker sores
- ❑ ❑ Frequent cold sores
- ❑ ❑ Chronic diarrhea
- ❑ ❑ Frequent vomiting

Hematologic/Endocrine/Immune Disorders

YES NO

- ❑ ❑ Blood transfusion
- ❑ ❑ Denied permission to give blood
- ❑ ❑ Anemia/Leukemia/Lymphoma
- ❑ ❑ Hemophilia
- ❑ ❑ Sickle cell disease
- ❑ ❑ Blood clots or Thrombosis
- ❑ ❑ Diabetes
- ❑ ❑ Thyroid disease
- ❑ ❑ Adrenal gland disease
- ❑ ❑ AIDS
- ❑ ❑ HIV infection
- ❑ ❑ Bleeding or bruising tendency
- ❑ ❑ Sudden weight loss or gain
- ❑ ❑ Frequent thirst
- ❑ ❑ Frequent hunger
- ❑ ❑ Frequent urination
- ❑ ❑ Cancer/Radiotherapy/ Chemotherapy
- ❑ ❑ Systemic Lupus

Psychiatric

YES NO

- ❑ ❑ Nervousness
- ❑ ❑ Depression
- ❑ ❑ Anxiety
- ❑ ❑ Past/present psychiatric treatment

Family History (Grandparents Parents. Sisters Brothers Children)

YES NO

- ❑ ❑ Diabetes
- ❑ ❑ Heart diseases
- ❑ ❑ Bleeding disorders

Allergies

YES NO

- ❑ ❑ Penicillin/Sulfa drugs
- ❑ ❑ Novocain/Xylocaine
- ❑ ❑ Aspirin/Codeine
- ❑ ❑ Latex products
- ❑ ❑ Other

FEMALES

YES NO

- ❑ ❑ Are your pregnant now? _____months
- ❑ ❑ Are your practicing birth control?
- ❑ ❑ Do you anticipate becoming pregnant?
- ❑ ❑ Are you breast feeding now?

(please turn over

Dental History:

YES NO

- ❑ ❑ Are you having pain or discomfort related to your mouth?
- ❑ ❑ Do you feel nervous about having dental treatment?
- ❑ ❑ Have you ever had a bad experience in a dental office?

Social History:

YES ___ NO ___ Do you use tobacco?

What kind? _____

How much _____

How may years? _____

YES ___ NO ___ Do you drink alcoholic beverages?

What kind? _____

How much per day? _____

How many years? _____

YES ___ NO ___ Past or current history of drug addiction

Do you have any other conditions not already mentioned?

_____

_____

History of Hospitalization/Surgical Procedures:

_____

_____

_____

_____

Current Medications:

Prescribed and over the counter medications taken within the last six months:

_____

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true. If ever have any change in my health, or my medicines change, I will inform my doctor at my next appointment.

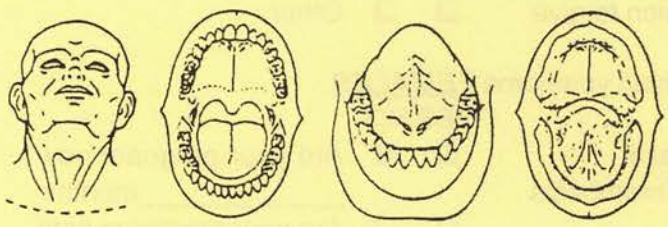
_____ _____

DATE Signature of Patient, Parent or Guardian

_____ _____

Doctor Witness

IV. Soft Tissue Examination (Indicate lesions on drawings, describe, and date)



Head, Neck, T.M.J.. _____

Lips/Frenum _____

Mucosa _____

Palate _____

Pharynx _____

Floor of Mouth _____

Tongue _____

Gingiva _____

Lymph Nodes _____

Salivary Glands _____

Thyroid _____

Significant Radiographic Findings:

_____

_____

_____

_____

_____

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Diane Folkes
(805) 983-0717/ (805) 987-1711
Staff@carsondds.com

Patient Acknowledgment

Patient Name(s): _____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

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.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Derek K. Carson, D.D.S., Inc.
LeRoy K. Carson, D.D.S.
Michael Acasio, D.M.D.
(805)983-0717 Oxnard
(805) 987-1711 Camarillo

INFORM CONSENT FORM

I understand that all financial responsibility for payment of dental services in this office for myself or dependents is mine and is due and payable at the time services are rendered unless other payment arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge will be added to the unpaid principal balance. In the event my account is referred to a collection agency I agree to pay all legal fees associated with this account.

I consider it my responsibility as a patient to be fully informed about my insurance benefits and I understand that to receive the best quality of care my recommended treatment will never be dictated by my dental insurance coverage. As a courtesy to our patients, our office will complete all necessary forms to expediate your dental claims, so you can maximize your insurance benefits per calendar year.

I understand that since appointment times are reserved for each patient I will be charges a $50.00 cancellation fee for a broken appointment without a 48-hour notice. A $150.00 charge will be assessed for broken sedation appointments.

Signature: _____ Date:_____

Derek K. Carson DDS, Inc.
LeRoy K. Carson DDS
126 West Deodar Avenue
Oxnard, California 93030
(805) 983-0717

Welcome to our practice! We are excited to have you as a patient and we would like to thank you for choosing our office. We like to interact with patients on social media, and not to mention give perks for check-ins. So, come follow our Carson family, @carson_dentistry126 or like us on Facebook. We like to build our Carson family on our social media accounts, so if you would like please provide your username below.

Instagram

Username: _____

Name: _____