244 E US Hwy 69
Suite 101
Claycomo, MO 64119

816-454-1313
info@claycomodental.com
www.claycomodental.com

Bryan D. Shewanick, D.D.S.
Morgan W. Turner, D.D.S.

Welcome!

Welcome to Claycomo Dental. We are very excited that you have chosen to see our practice for your dental needs. Before you can be seen there is a little bit of information that we need from you. In your "Welcome Packet" you will find the following:

- Map with Directions to the Office
- Registration and Medical History Forms
- Understanding Our Policies
- Authorization to Release and Discuss Dental Information
- Notice of Privacy Practices
- HIPPA Privacy Policy Acknowledgement

In order to make the registration process as smooth as possible, we ask that you fill out the forms ahead of time and arrive 10 minutes prior to your appointment time so that your care provider can be informed of your medical history. If you are unable to fill out the forms ahead of time, we ask that you arrive 20 minutes prior to your appointment to ensure you have ample time to provide all necessary information.

We look forward to seeing you soon. If you have any questions between now and the time of your appointment feel free to give us a call and we would be glad to assist you.

Thank you in advance for your cooperation,

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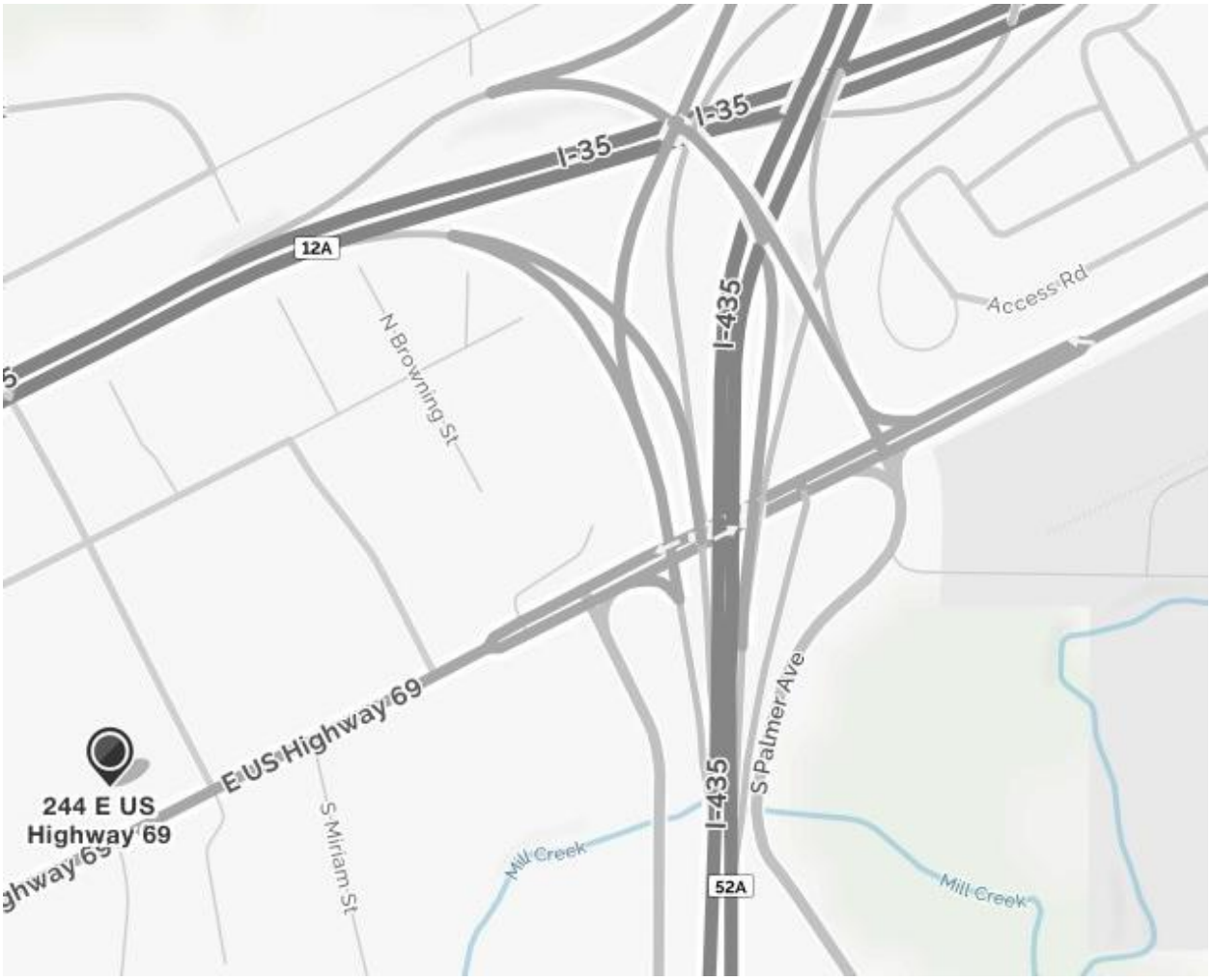
Map and Directions to Our Office

We are located in Claycomo, MO, northeast of the Ford Assembly Plant. We are up the road from I-435 and I-35. Our office is on the first floor of the Twin Center Professional Building next door to McDonald's. (Some GPS systems do no like our address. If you are having issues there are a couple of changes you could try: change the East to Northeast and make sure the city is Kansas City.) If you need any more help give us a call and we will try to help.



Claycomo Dental

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us.
If you have any questions, don't hesitate to ask.

Patient Information

Patient Name:	Date:
Address:	SSN:
City, State, Zip:	DOB: / /
☐ Male ☐ Female	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor
Employer:	Home Phone:
Occupation:	Work Phone:
E-mail:	Cell Phone:
Who should we thank for referring you?	
Do you prefer to be contacted for appointment confirmations via ☐ e-mail ☐ text ☐ phone?	
In case of emergency, who should we contact?	Phone:

Insurance Information

Primary Insurance	
Subscriber Name:	Subscriber DOB: / /
Subscriber SSN:	Subscriber Employer:
Insurance Company Name:	
Subscriber ID:	Group Number:
Secondary Insurance	
Subscriber Name:	Subscriber DOB: / /
Subscriber SSN:	Subscriber Employer:
Insurance Company Name:	
Subscriber ID:	Group Number:

Authorization & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Claycomo Dental 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 payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Date Relationship to Patient

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Responsible Party Signature Date Relationship to Patient

Medical History

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

What is the goal for your treatment today? _____

When was your last dental cleaning? _____ How often do you brush? _____ How often do you floss? _____

Check all that apply:

☐ Bad breath	☐ Bleeding gums	☐ Jaw clicking or pain	☐ Sensitivity to sweets
☐ Fingernail biting	☐ Grinding teeth	☐ Lip or cheek biting	☐ Sensitivity when biting
☐ Blisters on lips or mouth	☐ Orthodontic treatment	☐ Wear dentures/ partials	☐ Sensitivity to cold
☐ Periodontal treatment	☐ Tooth pain	☐ Frequent headaches	☐ Sensitivity to heat
☐ Jaw, head or neck injuries		☐ Loose teeth or broken fillings	

Are you pleased with the appearance of your teeth? _____

Are you under physician's care now? ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

_____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No Please list all medications (more room on back):

_____

_____

_____

Are you on a special diet? ☐ Yes ☐ No If yes _____

Do you use tobacco? ☐ Yes ☐ No

Women: Are you… ☐ Pregnant/ Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ NO Allergies	☐ Penicillin	☐ Aspirin	☐ Codeine	☐ Metal	☐ Latex	☐ Local Anesthetics
☐ Sulfa Drugs	☐ Acrylic	☐ Other? _____				

Do you have, or have you had any of the following?

☐ AIDS/ HIV Positive	☐ Cortisone Medicine	☐ High Blood Pressure	☐ Rheumatism
☐ Alzheimer's Disease	☐ Diabetes	☐ High Cholesterol	☐ Scarlet Fever
☐ Anaphylaxis	☐ Drug Addiction	☐ Hives or Rash	☐ Shingles
☐ Anemia	☐ Easily Winded	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Angina	☐ Emphysema	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Arthritis/ Gout	☐ Excessive Bleeding	☐ Kidney Problems	☐ Spina Bifida
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ Leukemia	☐ Stomach/ Intestinal Disease
☐ Artificial Joint	☐ Excessive Thirst	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Fainting Spells/ Dizziness	☐ Low Blood Pressure	☐ Swelling of the Limbs
☐ Blood Disease	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Blood Transfusion	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsilitis
☐ Breathing Problems	☐ Heart Attack/ Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Cancer	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Chemotherapy	☐ Heart Trouble/ Disease	☐ Psychiatric Care	☐ Venereal Disease
☐ Chest Pains	☐ Hemophilia	☐ Radiation Treatments	☐ Yellow Jaundice
☐ Cold Sores/ Fever Blisters	☐ Hepatitis A	☐ Recent Weight Loss	☐ Other _____
☐ Congenital Heart Disorder	☐ Hepatitis B or C	☐ Renal Dialysis	☐ Other _____
☐ Convulsions	☐ Herpes	☐ Rheumatic Fever	☐ Other _____

UNDERSTANDING OUR POLICIES

Thank you for selecting us as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. Your understanding of our policies is an essential element of your care and service.

- **We require ONE (1) business day to cancel or reschedule an appointment:**
  We work hard to accommodate appointments that fit your schedule and time is reserved *exclusively* for you. **We ask you let us know about changes at least 24 hours in advance.** Patients who cancel without sufficient notice more than once within a twelve-month period will be subject to a $25.00 missed appointment/cancellation fee. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee. Habitual missed appointments are grounds for dismissal from the practice.

- **Extended Appointments two (2) hours or more require a $50 deposit:**
  Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time, scheduled appointments over 2 hours require a deposit of $50.00. The deposit will be applied to payment due or refunded on the day of the appointment. If the deposit has not been paid two business days before your scheduled appointment, it will be cancelled.

  In the case of a failed or cancelled extended appointment with less than 24 hours-notice, the $50.00 fee is non-refundable.

- **Payment for services are due at the time services are rendered:**
  We accept cash, debit card, and for your convenience Visa, MasterCard, American Express, Discover and third-party financing through *CareCredit*. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service.

- **We will bill your insurance benefits for payment:**

Insurance is a contract between the patient and/or employer and the insurance company. It is your responsibility to make sure we have accurate and up-to-date insurance carrier information. We will be happy to assist you by filing your insurance claim and answering the details that the insurance company may require. We cannot be responsible for payment by the insurance company. *Regarding a Minor: the responsibility for payment belongs to the parent and/ or guardian.*

If your insurance has not paid within 90 days of services rendered, your claim will be closed and the remaining balance will automatically become patient responsibility. The insured has a better ability to deal with the insurance company and the employer responsible for the policy.

I have read and understand the Policies, and further I agree to accept these terms.

_____

Patient, Parent or Guardian Signature Date

_____

Patient's Name (please print)

Authorization to Release and Discuss Dental Information

Please provide all family members or friends you want us to be able to speak with about your dental treatment and care. You may opt out by checking the "DO NOT release Information" box below.

I give the following named person(s) authorization to take messages or speak with the office of Claycomo Dental, on my behalf, regarding (please check all items authorized):

Name of authorized person(s): _____ Relationship: _____

Phone number: _____

___Appointments ___Financial ___Dental Treatment ___Insurance ___Other

Name of authorized person(s): _____ Relationship: _____

Phone number: _____

___Appointments ___Financial ___Dental Treatment ___Insurance ___Other

Name of authorized person(s): _____ Relationship: _____

Phone number: _____

___Appointments ___Financial ___Dental Treatment ___Insurance ___Other

---

____DO NOT release information to anyone

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until notified by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's name: _____ Date: _____
Please Print Name

_____ _____
Signature of patient or patient's authorized representative Relationship to Patient

Effective date of notice: 08/13/2018

NOTICE OF PRIVACY PRACTICES

CLAYCOMO DENTAL LLC
244 E US Highway 69, Ste 101
Claycomo, MO 64119
P: (816) 454-1313
F: (816) 454-5377
info@claycomodental.com
Contact: Karen Mychalczuk

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day

extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

HIPAA Privacy Policy Acknowledgement

Name: _____ Date of Birth: _____

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURES

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relation to Patient: _____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them, which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relation to Patient: _____