Stedman-Wade Health Services, Inc.

Wade Family Medical Center
P.O. Box 449
7118 Main St.
Wade, NC 28395
(910) 483-6694
(910) 483-2215(Fax)
E-Mail: info@swhs-nc.org

VISIT OUR WEBSITE
WWW.SWHS-NC.ORG
Accredited by the Joint Commission

Stedman Family Dental Center
P.O. Box 268
6540 Clinton Rd.
Stedman, NC 28391
(910) 483-3150
(910) 483-2845 (Fax)
E-Mail: om@swhs-nc.org

Dear _____,

Welcome!

On behalf of the Providers and Staff of Stedman Family Dental Center (SFDC) we would like to thank you for choosing us to be your primary care providers.

Stedman-Wade Health Services, Inc. (SWHS, Inc.) has been in existence since 1978 doing business as Wade Family Medical Center and Stedman Family Dental Center. SWHS, Inc. received accreditation from the Joint Commission in February 2002 demonstrating SWHS, Inc.'s commitment to quality care, continuous improvement and patient satisfaction.

Our offices accept assignments of Medicare (medical only), Medicaid, and most third party insurance carriers. For your convenience, we accept Master Card, Visa, Discover, and debit cards, in-state personal checks and cash.

Should you have any questions, please do not hesitate to call our office.

Again, Welcome to Stedman Family Dental Center.

Sincerely,

Stedman Family Dental Center Staff

"WHERE HEALTH CARE IS A FAMILY AFFAIR"

"Our mission is to provide quality, accessible, affordable primary and preventive medical and dental health care in a compassionate and cost effective manner to all populations."

Your COMMUNITY HEALTH CENTER

PATIENT RESPONSIBILITES

1. **YOU** are responsible for keeping appointments and for notifying the Center in advance when you are unable to keep your appointment.

2. **YOU** are responsible for following the medical provider's plan of care. Medications should be taken as prescribed by the provider and the patient should return to the clinic for treatment as the provider requests. You are responsible for seeking clarification when necessary to fully understand your health problem and the proposed plan of care.

3. **YOU** are responsible for providing complete and accurate information about your identity, demographics, insurance and answer other reasonable questions that will assist SWHS, Inc. in providing appropriate care and obtaining payment. This includes reviewing and signing all necessary consents, financial agreements, or other documents required by the facility.

4. **YOU** are responsible for bringing your Medicaid, Medicare and any other insurance card to each visit.

5. **YOU** are responsible for providing accurate information about your present illness, medications, past medical or health history, including any hospitalizations or any changes in your condition.

6. **YOU** are responsible for supervising your children, both inside and outside the facility. Parents will be held responsible for the actions of their children. Children under the age of 12 should not be left unsupervised if at all possible.

7. **YOU** are responsible for making financial arrangements regarding your bill prior to the time of service.

8. **YOU** are expected to conduct yourself in a courteous, friendly, and respectful manner toward fellow patients and members of the staff. Appropriate conduct is expected of all the patients and visitors at all times. Threatening, violent, abusive, disruptive or loud behavior is inappropriate. SWHS, Inc. reserves the right to ask you and your family/guest to leave or have you removed from the property.

9. There will be no alcohol, drugs, and/or weapons permitted on the premises. Patients, who arrive at the Center under the influence and do not require urgent care, will be asked to leave. If you refuse, the Sheriff's Department will be contacted for assistance.

PATIENT RIGHTS

1. YOU have the right to obtain information concerning your diagnosis, treatment and prognosis. If the Health Care Provider believes it is medically inadvisable to give information to the patient, it must be made available to an appropriate representative of the patient. The name of the Health Care Provider must be made available upon request.

2. YOU have the right to considerate and respectful care.

3. YOU have the right to receive information necessary to give your informed consent prior to the start of any procedure or treatment and to information regarding alternative procedure or treatments available.

4. YOU have the right to refuse treatment to the extent permitted under law and that you will be fully informed of the medical consequences of refusal.

5. YOU have the right to privacy concerning your medical records pertaining to your care and have your permission to be present during case discussion, examination or treatments.

6. YOU have the right to confidential treatment of all records pertaining to your care and have the opportunity to approve or refuse their release to any individual, except as required by law or third party payment contracts.

7. YOU have the right to reasonable response to your request for services. If transfer to another facility is recommended by the Health Care Provider, the patient must be given full information and explanation of need for transfer and any possible alternatives.

8. YOU have the right to know the relationship between this Center and any other health care institution involved in your care.

9. YOU have the right to expect reasonable continuity of care and to be informed of continuing health care requirements after discharge from the Center.

10. YOU have the right to be informed of any Center rules and regulations that relate to your conduct as a patient.

11. YOU have the right to examine your bill and receive any explanation of all or any charges, regardless of method of payment

STEDMAN-WADE HEALTH SERVICES, INC. does NOT deny treatment which is available and medically indicated to any person on the basis of AGE, SEX, RACE, COLOR, CREED, NATIONAL ORIGIN OR THE SOURCE OF PAYMENT!

Stedman-Wade Health Services, Inc.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose you protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect, Food and Drug Administration requirements;

Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and

Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Service to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. We may assess a fee for copying your records.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer, Chris Henley (910) 483-6694 ext. 7002. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

PATIENT REGISTRATION
PLEASE PRINT

PATIENT INFORMATION

PATIENT FULL NAME_____ DATE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE NO_____ CELL PHONE NO_____ E/MAIL_____

WORK NO_____ SOCIAL SECURITY NO_____ DATE OF BIRTH_____

RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ HISPANIC ☐ ASIAN ☐ NATIVE AMERICAN ☐ OTHER

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____ PHONE NO _____

RESPONSIBLE PARTY

NAME OF RESPONSIBLE PARTY_____ RELATIONSHIP TO THE PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

DRIVER'S LICENSE NO_____ DATE OF BIRTH_____ SOCIAL SECURITY NO_____

EMPLOYER_____ WORK NO_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE: ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY NAME_____

CLAIM MAILING ADDRESS_____ CITY_____ STATE_____ ZIP_____

POLICY NUMBER_____ GROUP NO_____ GROUP NAME_____

NAME OF INSURED_____ PHONE NO_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

SECONDARY DENTAL INSURANCE COMPANY NAME_____

CLAIM MAILING ADDRESS_____ CITY_____ STATE_____ ZIP_____

POLICY NUMBER_____ GROUP NO_____ GROUP NAME_____

NAME OF INSURED_____ PHONE NO_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

X_____

Signature of Patient/Guardian Date

Stedman Family Dental Center
6540 Clinton Road
Stedman, NC 28391

Patient Name: _____
Chart No: _____
Date Of Birth: _____

DATE: _____

Name of Your Physician: _____ Office Telephone: _____

Address of Your Physician: _____

Name of Your Pharmacy: _____

1. Have you ever been hospitalized, had any major operations or had any serious illnesses?.....Yes No
   If yes, explain: _____
   _____
   _____
2. Have been under a physician's care in the last 2 years? .....Yes No
   If yes, explain: _____
   _____
   _____
3. With regard to cigarette smoking, how would you classify yourself? Current smoker Ex-smoker Never smoker
4. Do you currently use smokeless tobacco (e.g., snuff, plug)? .....Yes No
   If yes, about how many times do you use smokeless tobacco per day? Less than 1 1-5 6-10 11-20 more than 20
5. Do you currently drink alcoholic beverages? .....Yes No
   If yes, about how many drinks do you have per week? Less than 1 1-5 6-10 11-20 more than 20
6. Do you have (or have you ever been told you had) any of the following conditions? (circle all that apply)
   a. Congenital heart problems
   b. Infective endocarditis or other heart infection
   c. Artificial heart valves
   d. Heart Transplant
   e. Artificial joints or prostheses

7. Have you ever had an allergic reaction, or any other unusual reaction, to any of the following medications or substances?
   If yes, what reaction(s) did you have to this substance? (circle all that apply)

A	**Penicillin**	**Yes No**	**Rash**	**Swelling**	**Upset Stomach**	**Vomiting**	**Other reaction (explain)**
B	Sulfa or other antibiotics	Yes No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)
C	Aspirin	Yes No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)
D	Codeine or morphine	Yes No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)
E	Dental anesthetic (e.g. Novocain or lidocaine)	Yes No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)
F	Latex	Yes No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)
G	Airborne substances (e.g. pollen, perfume)	Yes No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)
H	Other medications or substances (explain)						

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Patient Name: _____
Chart No: _____
Date Of Birth: _____

8. Do you have (or have you ever been told you had and of the following conditions?

A	High blood pressure (hypertension)	Yes	No	Don't know
B	High cholesterol	Yes	No	Don't know
C	Heart disease (e.g. angina, coronary artery disease, congestive heart failure)	Yes	No	Don't know
D	Diabetes (sugar disease, blood sugar problems)	Yes	No	Don't know
E	Cancer or tumors	Yes	No	Don't know
F	Inflammatory diseases (e.g. arthritis, rheumatism, lupus, fibromyalgia)	Yes	No	Don't know
G	Frequent headaches	Yes	No	Don't know
H	Asthma, emphysema, or other lung disease	Yes	No	Don't know
I	Thyroid problems	Yes	No	Don't know
J	Epilepsy or seizure disorders	Yes	No	Don't know
K	Fainting or dizzy spells	Yes	No	Don't know
L	Hepatitis or other liver disease	Yes	No	Don't know
M	Tuberculosis (TB)	Yes	No	Don't know
N	HIV+ or AIDS	Yes	No	Don't know
O	Blood disorders (e.g. anemia, hemophilia)	Yes	No	Don't know
P	Kidney disease	Yes	No	Don't know
Q	Stomach or intestinal problems	Yes	No	Don't know
R	Phobias, sever anxieties, depression or other psychological problems	Yes	No	Don't know
S	Radiation, surgery, or chemotherapy to treat cancer	Yes	No	Don't know
T	Bleed excessively after being cut or receiving dental care	Yes	No	Don't know
U	Heart attack, stroke, or coronary bypass operation	Yes	No	Don't know
V	Shortness of breath after climbing 1 flight of stairs	Yes	No	Don't know
W	Pacemaker	Yes	No	Don't know
X	Pregnant or think you may be pregnant	Yes	No	Don't know
Y	Breastfeeding	Yes	No	Don't know

Z. Are there any other problems or issues about your health that you know of? .....Yes No

If yes, explain: _____

_____

_____

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Patient Name: _____
Chart No: _____
Date Of Birth: _____

9. Have you ever taken medications (such as bisphosphonates) that affect the bone or to prevent bone disease (e.g. Fosamax, Zometa, Actonel, Aredia)? .....Yes No

10. Are you currently taking any medications or substances, including over-the-counter, prescription, vitamin, or herbal products, for any reason? Please list below.....Yes No Don't Know

Medications or substances (with dosage)

_____
_____
_____
_____
_____
_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical and or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature: _____ Date: _____
If other than patient, indicate relationship to patient: _____
Provider Signature: _____

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Patient Name: _____
Chart No: _____
Date Of Birth: _____

DATE: _____

1. What is you major dental concern? (circle all that apply)
   I need a dental checkup My teeth hurt My gums hurt
   I have some teeth that are chipped or broken I don't like that appearance of my teeth or gums

2. How long ago was your last dental checkup and/or cleaning?
   Less than 1 year ago 1-2 years ago More than 2 years ago I've never had a dental checkup and/or cleaning

3. How often do you brush your teeth?
   More than once a day Once a day Once or twice a week Hardly ever Never

4. How often do you use dental floss?
   More than once a day Once a day Once or twice a week Hardly ever Never

5. Which of the following oral health care products do you use regularly? (circle all that apply)
   Fluoridated toothpaste Fluoridated mouthrinses Fluoridated water at home Other Fluoridated products
   Other non-fluoridated products

Do the following things happen often enough to bother you?

6.	Food or dental floss gets caught between my teeth	Yes	No
7.	Gums bleed or hurt when I brush my teeth	Yes	No
8.	My teeth are sensitive to heat	Yes	No
9.	My teeth are sensitive to cold	Yes	No
10.	My teeth are sensitive to biting	Yes	No
11.	My teeth are sensitive without any stimulus at all	Yes	No
12.	I clench or grind my teeth	Yes	No
13.	I have pain or clicking in my jaw joints	Yes	No
14.	I get sores in my mouth	Yes	No
15.	I have bad breath	Yes	No

16. Which of the following dental treatments have you had? (circle all the apply)
    Root Canal Therapy Crowns ("Caps") Bridges Removable Dentures Tooth Removal Gum Surgery
    Dental Implants

17. Which statement best describes your approach to dental care? (circle one)
    I go to the dentist regularly even if I don't have problems
    I don't go to the dentist unless I have a problem

18. Have you ever had problems or complications with previous dental treatment? .....Yes No

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Patient Name: _____
Chart No: _____
Date Of Birth: _____

19. Is there anything about dental care that worries you or that you strongly dislike? .....Yes No

20. Do you have any questions about your teeth, gums, or oral health? .....Yes No

STEDMAN-WADE HEALTH SERVICES, INC.

ANNUAL PATIENT INFORMATION UPDATE
January – December _____

PATIENT NAME: _____ DOB: _____

PHONE #: _____ CELL/WORK #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

RELATIONSHIP TO EMERGENCY CONTACT: _____

NEXT OF KIN: _____ PHONE #: _____

EDUCATION LEVEL: _____ HOMELESS STATUS: YES or NO

HEALTH INSURANCE: _____ VETERAN: YES or NO (Circle one)

YEARLY HOUSEHOLD ESTIMATE

STEDMAN-WADE HEALTH SERVICES, INC. IS REQUIRED TO REPORT INCOME DATA ON OUR PATIENTS IN ORDER TO RECEIVE FEDERAL FUNDING TO SERVE THE UNINSURED. THIS INFORMATION **IS** CONFIDENTIAL. REPORTING IS AGGRAGATE AND NOT PATIENT SPECIFIC.

YEARLY HOUSEHOLD ESTIMATE
PLEASE CIRCLE INCOME AND FAMILY SIZE

Size of Family Unit	Income	Income	Income	Income	Income
1	0–11,770	11,771–14,713	14,714-17,655	17,656-20,598	20,599-22,363
2	0-15,930	15,931-19,913	19,914-23,895	23,896-27,878	27,879-30,267
3	0-20,090	20,091-25,113	25,114-30,135	30,136-35,158	35,159-38,171
4	0-24,250	24,251-30,313	30,314-36,375	36,376-42,438	42,439-46,075
5	0-28,410	28,411-35,513	35,514-42,615	42,616-49,718	49,719-53,979
6	0-32,570	32,571-40,713	40,714-48,855	48,856-56,998	56,999-61,883
7	0-36,730	36,731-45,913	45,914-55,095	55,096-64,278	64,279-69,787
8	0-40,890	40,891-51,113	51,114-61,335	61,336-71,558	71,559-77,691

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PATIENT CARE REPRESENTATIVE **DATE**

General Dentistry Informed Consent Form

1. Treatment Plan: I understand the recommended treatment and my financial responsibility as explained to me. I understand that, by signing this consent, I am in no way obligated to any treatment. I also acknowledge that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures.

2. Drugs and Medications: I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swelling, pain, itching, vomiting and/or anaphylactic shock.

3. Extractions: Alternative to removal of teeth have been explained to me (root canal therapy, crown and bridge procedures, periodontal therapy, etc.). I understand removing teeth does not always remove infection, if present and further treatment may be necessary. I understand the risks involved in having teeth removed such as pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue, and surrounding tissues (paresthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost which is my responsibility.

4. Crowns, Bridges, and Veneers: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which come off easily, and that I must be careful to ensure they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape, size, fit, color) is before cementation. It is also my responsibility to return for permanent cementation within 20 days of tooth preparation. Excessive delays may allow for tooth movement which could lead to remaking the crown or bridge. I understand there will be additional charges for remakes due to delay of permanent cementation.

5. Endodontic Therapy: I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from treatment, and that occasionally root canal filling material may extend through the tooth which does not necessary affect the success of treatment. I understand that endodontic files and reamers are very fine instruments and stresses and defects in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures (apicoectomy) may be necessary following root canal treatment. I understand that the tooth may be lost in spite of all efforts to save it.

6. Periodontal Disease: If diagnosed, I understand that periodontal disease is a serious condition that causes inflammation and loss of gum and bone tissue that ultimately leads to loss of teeth. Alternative treatments, including gum surgery, tooth extraction, and/or replacement, have been explained to me.

7. Fillings: I understand that care in chewing must be exercised to avoid breakage during the first 24 hours following a filling. I understand that a more extensive restoration procedure that originally diagnosed may be required due to additional or extensive decay. I understand that significant sensitivity is common with new fillings.

8. Partials and Dentures: I understand wearing partials or dentures is difficult. Sore spots, altered speech, and difficulty eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjustment and several relines. A permanent reline will be needed at a later date. This is not included

understand that failure to keep a delivery appointment may result in poor fitting dentures. If a remake is required due to my delays of more than 30 days, additional charges could be incurred.

I understand that dentistry is not an exact science and, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding any dental treatment which I have requested and authorized.

Patient (or Guardian) Signature: _____ Date: _____

EMERGENCY CONSENT FORM

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Stedman Family Dental Center providers and/or such associates or assistants as he/she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any local anesthetic or therapeutic agent, including those related to restorative, palliative, therapeutic or surgical instruments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.

_____ _____

Signature of Patient, Legal Guardian, or Authorized Agent of the Patient

Date

STEDMAN FAMILY DENTAL CENTER

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Stedman Family Dental Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Stedman Family Dental Center. I understand that diagnosis or treatment of me by the healthcare providers of Stedman Family Dental Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Stedman Family Dental Center is not required to agree to the restrictions that I may request. However, if Stedman Family Dental Center agrees to a restriction that I request, the restriction is binding on Stedman Family Dental Center and its providers and staff.

I have the right to revoke this consent in writing, at any time, except to the extent Stedman Family Dental Center has taken action on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This "Protected Health Information" relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand I have the right to review Stedman Family Dental Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types and uses of disclosure of my protected health information that may occur in my treatment, payment of my bills or in the performance of health care operations of Stedman Family Dental Center.

The Notice of Privacy Practices for Stedman Family Dental Center is located at the reception desk. This Notice of Privacy Practices also describes my rights and Stedman Family Dental Center's duties with respect to my information.

Stedman Family Dental Center reserves the right to change privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised coy be sent in the mail or asking at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

STEDMAN FAMILY DENTAL CENTER
FINANCIAL POLICY SHEET

The staff of Stedman Family Dental Center would like to thank you for choosing us to provide you and /or your family with quality dental care. It is our mission to provide quality, accessible, affordable, primary and preventive medical and dental health care in a compassionate and cost effective manner to all populations.

To help keep the cost of billing down, we ask that all fees be paid at the time of service. If you have insurance, we will be happy to file it for you. Please make sure that you notify the staff of any changes in your insurance carrier and provide us with a copy of your current card. All co-pays and non-allowed services must be paid at time of visit. Patients are responsible for any balances remaining after the assignment and payment of insurance benefits. Sliding Fee payments are due at the time of service. We gladly accept cash, checks, Debit, Visa, Master Card, Discover, and American Express cards.

Please be aware that all accounts over 120 days old will be turned over to a collection agency. Accounts that are turned over to a collection agency will be subject to collection fees. Please call and speak with our Insurance Billing clerks if you are in need of a payment arrangement plan.

There is a $30.00 fee for all returned checks.

_____ _____

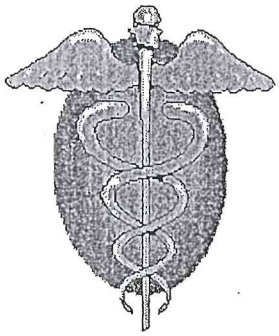
PRINT NAME OF RESPONSIBLE PARTY SIGNATURE OF RESPONSIBLE PARTY

_____ _____

SIGNATURE OF PATIENT REPRESENTATIVE DATE

Stedman-Wade Health Services, Inc.

Wade Family Medical Center
P.O. Box 449
Hwy 301 North
Wade, NC 28395
(910) 483-6694
(910) 483-2215 (Fax)
E-Mail: info@swhs-nc.org



Stedman Family Dental Center
P.O. Box 368
6540 Clinton Road
Stedman, NC 28391
(910) 483-3150
(910) 483-2845 (Fax)
E-Mail: om@swhs-nc.org

VISIT OUR WEBSITE
WWW.SWHS-NC.ORG
Accredited by the Joint Commission

Date_____

Patient's Name_____

Medicaid ID#_____

To the best of my knowledge, I have **not** had any radiographs (**x-rays**) paid for by North Carolina Medicaid in the last 5 years.

If Medicaid denies payment for any new radiographs because they have paid for radiographs previously in the last 5 years, I understand that I may be responsible for the full fee of said radiographs to **Stedman Family Dental Center.**

Signature_____
(Parent if patient is a minor)

I have had radiographs paid for by North Carolina Medicaid in the last 5 years.

Dentist Name:_____

Address: _____

_____

Telephone Number:_____

I understand that if Stedman Family Dental Center is unable to obtain duplicates of my previous radiographs, I may be responsible for the fee for new radiographs.

Signature:_____
(Parent if patient is a minor)

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www.swhs-nc.org

NO SHOW POLICY

A pattern of repeated "no shows" for appointments will result in dismissal from this dental practice. A "no show" is defined as a missed appointment in which the individual does not call to cancel or reschedule the appointment 24 hours prior to the appointment time.

Your signature below indicates that you are aware and understand this policy. Should you have any questions, please direct them to the patient representative at the front desk.

_____ _____

Signature of patient, if minor, signature of responsible party

Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other