

Welcome to Our Office

Dr. August J. Durso, Jr. D.D.S.
1728 E. Kensington Road • Mt. Prospect, IL 60056 • (847) 635-0117

Welcome

Thank you for choosing our office for your dental care needs. It is our goal to provide you with the very best dental care in a friendly and comfortable environment. We understand the importance of excellent dental care and the positive impact a confident smile can make in your life.

Please fill out the following forms:

- * Patient Registration
- * Medical History
- * Financial Policy
- * Appointment Cancellation Policy
- * HIPAA Notices of Privacy Practices

As a courtesy to our patients, we will file your insurance claim with your insurance carrier. When your insurance company pays, any outstanding balance is your responsibility. Payment will be due in full at the time of the billing. Our office is unable to carry outstanding balances.

In some cases, a treatment plan may exceed your insurance carrier's coverage limit. To help make cosmetic and emergency dental services more affordable, our practice offers an easy to use finance program through our patient financing service, Chase Health Advance.

By completing a simple registration form, we can pre-qualify you while you are here. Our finance program offers a 6, 12 or 18 month same as cash option and no penalty for early payoff. You may use our finance program for all or part of your procedure. There is no application fee and is strictly voluntary on your behalf.

Once again, thank you for choosing our office.

August J. Durso, Jr., D.D.S

PATIENT REGISTRATION

Dr. August J. Durso, Jr. D.D.S.
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ID: _____ Chart ID _____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient Is: Policy Holder Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ ext _____

Cellular: (____) _____ Pager: (____) _____

Birth Date: _____ Social Security (Soc Sec.) Number: _____

Drivers License: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ ext _____

Cellular: (____) _____ Pager: (____) _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Last Dental Visit: _____

Referred By: _____

Emergency Contact: _____

Phone: (____) _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Medical History

Dr. August J. Durso, Jr. DDS., LTD
1728 E. Kensington Road • Mt. Prospect, IL 60056 • (847) 635-0117

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your 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.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women are you: Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

- | | | | |
|---|---|--|---|
| AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells /Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack /Failure <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores /Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pace Maker <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

Financial Policy

Dr. August J. Durso, Jr. D.D.S.
1728 E. Kensington Road · Mt. Prospect, IL 60056 · (847) 635-0117

Dear Valued Patient,

It is our policy to collect payment for treatment performed at the time of service. When you require treatment, we will provide you with the following options for payment.

1. Our office policy is that all Cleanings, Exams, Radiographs, and all services under \$300.00, are to be paid in full at the time of service. As a courtesy to our patients, we will file your insurance claim with your insurance carrier.

2. Pay in full in advance for all services over \$1,200.00. Since it requires less administration on our part, should you choose this option we will extend a 5% discount on the amount you pay in advance. In the case where you do have insurance coverage, we will file insurance for the portion of the fee that we estimate they will cover, and you will pay the estimated balance due in advance. Once payment from insurance has been received, if there is any balance remaining, it will be billed to you. If the payment from insurance results in a credit balance, this will be refunded to you.

3. Financing. Our office uses Unicorn Financial Services for financing to patients specifically for their dental treatment. This allows you to spread out the cost of your treatment over time with no interest charges. This also alleviates the need to collect at each appointment, allowing you to proceed with your treatment in a timely manner while making low monthly payments.

4. Automatic monthly credit card payments depending on the amount of treatment and approved by the financial coordinator.

Credit Card Number _____
Visa - MasterCard – Discover

Expiration Date _____ V-Code _____

5. For procedures requiring 60 minutes or more, a 50% advance deposit will be required. The remaining balance will be paid upon arrival for the completion appointment.

We will provide you with a copy of any and all financial arrangements we make with you so that you have them to refer to in the future.

We strive to ensure you are informed of all of our policies and procedures up front, and to make all aspects of your experience with us comfortable for you as possible. We are happy to answer any questions you might have regarding such policies and procedures now or in the future as they arise.

I have read and I understand the above Patient Payment Policy and I have been provided with the answers to any questions I have at this time.

Patient Signature

Date

Appointment Cancellation Policy

Dr. August J. Durso, Jr. D.D.S.
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Dear Valued Patient,

Our purpose is to help our patients keep their teeth and gums healthy for life. Proper scheduling of appointments is vital to that endeavor. Therefore, we ask for your cooperation regarding the following appointment policy:

1) Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. We try to remind patients by telephone prior to their appointment, but please do not depend on this courtesy. If we are unable to reach you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present. That time has been reserved especially for you. This means no other patient has been scheduled for that particular time slot and that anyone else wishing to schedule for that time has had to be given a different time for their appointment. We reserve the right to charge for office visits cancelled or broken without 48 business hours advance notice. Exceptions to this policy can be determined only on an individual basis according to the circumstances. The broken appointment charge will depend on the procedure and time reserved. These charges are allowed by your insurance company but considered as the patient's responsibility to pay.

2) In order to ensure that we keep to our schedule, and yours, as much as possible and to minimize patient waiting time, it is necessary to schedule certain procedures for specific times during the day. This allows us to provide you with the excellence in care that you expect and deserve. We know your time is valuable and that none of our patients want to spend any longer in the dentist's office than they have to. Scheduling specified procedures for specific time slots allows us to be more efficient with your treatment and actually minimizes the time you have to spend at our office.

If you have any questions about the policy, do not hesitate to ask our office staff. We believe that good communication is the key to excellence in dental care.

I have read and I understand the above Patient Appointment Policy, and I have been provided with the answers to any questions I have at this time.

Patient Signature

Date

HIPAA Notice of Privacy Practices

Dr. August J. Durso, Jr. D.D.S.
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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

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 your 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 b)' the Secretary of the Department of Health and Human Services 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.

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Your Rights

Following 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, 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,

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 health care 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 then have the right to use 'another Healthcare Professional.

You have the-right to request to receive confidential communications 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 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 to 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 contact of your complaint. We will not retaliate against you for filing a complaint.

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practice.

Print Name: _____

Signature: _____ Date: _____