NORTHERN KENTUCKY ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES P.S.C.

HANK W. SLEET, M.D., D.M.D.
TODD M. JACOBS, D.M.D. ERIC M. MENCARELLI, M.D., D.D.S.

PATIENT INFORMATION

NAME _____ SS# _____ DOB _____ AGE _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK# _____ CELL _____

EMPLOYER _____

PHYSICIAN _____ DENTIST _____ REFERRED BY _____

CHECK WHATEVER APPLIES

1. _____ Allergy to drugs or medication _____
2. _____ Taking medication regularly _____
3. _____ _____
3. _____ Presently under care of physician _____
4. _____ Excessive bleeding, which required special treatment
5. _____ Heart disease/mitral valve prolapse _____
6. _____ Rheumatic fever _____
7. _____ High blood pressure or stroke_____
8. _____ Breathing disorder, short of breath or cough _____
9. _____ Allergies or asthma
10. _____ Diabetes
11. _____ Epilepsy or seizure disorder
12. _____ Hepatitis or liver disease
13. _____ HIV disease
14. _____ Nervous or emotional disorder
15. _____ Women, are you pregnant?
16. _____ If visit is due to injury, date of injury _____
17. _____ Do you use tobacco products?

In case of emergency _____ Phone# _____

SUBSCRIBER *(Insurance Policy Holder)*

NAME _____ SS# _____ DATE OF BIRTH _____ AGE _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK# _____ OTHER # _____

RELATION TO PATIENT_____

INSURANCE INFORMATION

	Dental Insurance	Medical/Surgical Insurance
Insurance Company		
Address		
Policy Holder		
Employer		
Group#		
ID# or SS#		

I authorize the release of any information relating to my treatment. I understand that I am responsible for all costs of treatment. I hereby authorize payment of group insurance benefits otherwise payable to me to be paid directly to Northern Kentucky Oral and Maxillofacial Surgery Associates P.S.C.

SIGNED: _____ DATE: _____

If under 18 years of age parent or guardian must sign.

HEALTH HISTORY & PHYSICAL

RADIOLOGY:

DIAGNOSIS:

TREATMENT RECORD

Established 1918
Fellow
American Association of
Oral and Maxillofacial Surgeons
Diplomate
American Board of
Oral and Maxillofacial Surgeons

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20 MEDICAL VILLAGE DRIVE, SUITE 196
EDGEWOOD, KY 41017

4748 HOUSTON ROAD
FLORENCE, KY 41042

4465 ALEXANDRIA PIKE
COLD SPRING, KY 41076

Patient Name _____

I hereby authorize treatment of the patient above by the physicians and employees of Northern Kentucky Oral and Maxillofacial Surgery Associates, for medical and surgical procedures and related services on a scheduled or emergency basis. I agree to take full steps necessary for the submission of insurance claims relating to services provided by the office of Northern Kentucky Oral and Maxillofacial Surgery Associates, for the patient named above. I authorize payment of benefits to the Northern Kentucky Oral and Maxillofacial Surgery Associates. I certify that I have been informed that health or dental insurance may not exist for services for any of the following reasons:

- I may have a pre-existing condition or other diagnosis that may not be covered by my health care plan.
- I have not obtained a necessary referral from my health care plan.
- My health care plan may not have established medical necessary for the services.
- There is an unmet deductible under the plan.
- The services are not covered under my health care plan.

With the above knowledge, I request that services be performed and I agree that I am ultimately responsible for the charges incurred by me. If services are not covered by my insurance plan I am responsible for the remaining balance. If the insurance estimates an amount that they will not cover, I will pay that upfront. I am aware that it is only an estimate and they may not pay anything at all, or only some of what they estimate to pay. If a balance is due, I will pay it within reasonable time or legal action will be taken to insure payment. In the event that my account becomes delinquent or past due, I understand that I am responsible for all collection fees, interest accrual, attorney fees, or court costs.

I also give permission to send lab reports, X-rays and Dr's notes to the insurance companies in order for a decision of their payment to be made on the claim. I also give permission for lab specimen's, if any are taken, may be sent to whatever lab necessary in order to determine diagnosis.

I acknowledge that I have been given the opportunity to review a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice, and understand that a copy will be made available to me upon request.

_____ _____

Signature Date

Northern Kentucky Oral and Maxillofacial Surgical Associates

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.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect December 17th, 2014 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the

possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so.

(You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice.

If you request copies, we will charge you $0.10 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (you must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the addresses or phone numbers listed on this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Hank W. Sleet, M.D., D.M.D.

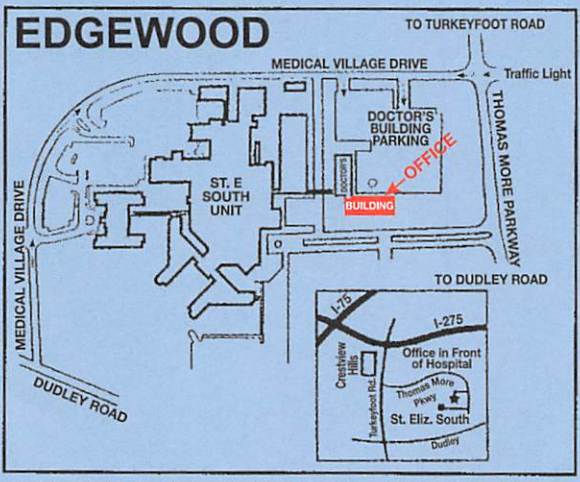
Eric M. Mencarelli, M.D., D.D.S.

Todd M. Jacobs, D.M.D.

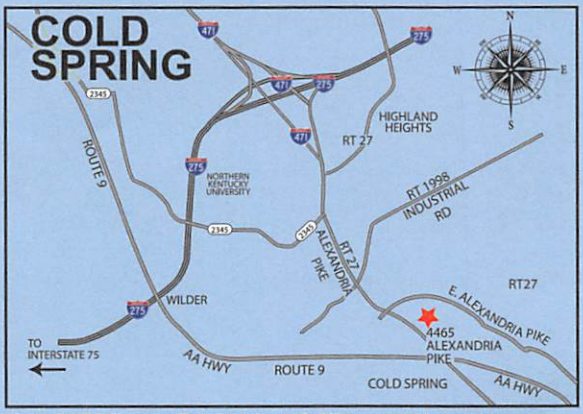
20 Medical Village Drive, Suite 196	4748 Houston Road	4465 Alexandria Pike
Edgewood, Ky. 41017	Florence, Ky. 41042	Cold Spring, Ky. 41076
(859) 331-2100	(859) 371-5666	(859) 441-1111

Exit from I-75 Southbound – Take Exit 184 (KY-236). Turn right onto Donaldson Road (KY 236 W). Turn left onto Houston Road. Destination will be on left directly in front of Lowe's.

Exit from I-75 Northbound – Take Exit 182 (KY-1017/Turfway Road). Turn left onto KY-1017/Turfway Road. Turn right onto Houston Road. Destination will be on right directly in front of Lowe's.



Exit I-75 to I-275E (1.0 miles) to Turkeyfoot Rd. Exit 82. Right on Turkeyfoot Rd. (.3 miles). Left on Thomas More Pkwy (1.0 miles). Doctor's building is on the right, attached to St. Elizabeth Hospital.



Take I-275 East to Exit 74A for US-27 toward Alexandria. Continue onto US-27 S/Alexandria Pike to 4465 Alexandria Pike.