ORAL SURGERY ASSOCIATES OF
NORTHERN VIRGINIA, LTD.

1800 TOWN CENTER DRIVE, RESTON, VA 20190 (703) 435-4414
3158 GOLANSKY BLVD. WOODBRIDGE, VA 22192 (703) 897-8983

Practice and Financial Policies

Thank you for choosing Oral Surgery Associates of Northern Virginia, Ltd. We are committed to providing you with the best medical care possible. Managed care and increasing malpractice costs have forced us, however, to reconstruct some of the ways in which we handle our financial policies. The cost of providing medical care has risen dramatically while the fees we receive from insurance have greatly decreased. We have had to increase our administrative staff to accommodate the additional work that insurance companies require in order to receive reimbursement for our services.

Because of these factors, we have found it necessary to change our policies to operate as efficiently as possible.

FINANCIAL POLICIES

Insurance: We file the insurance claim as a courtesy to our patients, but all charges are your responsibility from the date of service rendered. Not every service is a covered benefit under all contracts. It is important that you read and understand YOUR health insurance policy and its requirements for coverage including pre-authorization of services. We currently send claims to over 600 plans and are not responsible for knowing the requirements of your specific plan. If you provide outdated or incorrect insurance information, you will be responsible for any denied claims. Most plans have a timely filing period so it is important that the information you provide our practice is the most current available.

Secondary insurances: We do not file secondary insurance. If you need a copy of your original claim for your secondary carrier, please call the office and one will be mailed to you. Please keep in mind, the secondary carrier pays only after the primary carrier has paid. A copy of the "Explanation Of Benefits" from your primary carrier should accompany this claim.

Copays: Per your insurance company, your copay must be paid at the time services are rendered.

Deductibles and Co-insurances: These fees are due at the time of service. We accept cash, checks, debit cards, Visa and Mastercard. We use Telecheck to verify check information. There is a $35.00 returned check fee.

Procedures not covered by insurance: All payments are due on the day of service.

Late Policy: If you are more than 15-20 minutes late, every effort will be made to fit you into the schedule. If our schedule is too full, we will ask that you reschedule your appointment.

Copies of Medical Records: Our fee for this service is based on Virginia Code 8.01-413B which requires that records be provided within 15 days for a charge not to exceed fifty cents per page for the first 50 pages and twenty-five cents for each additional page and a fee not to exceed $10.00 for searching, handling and mailing the records.

The above is a summary of our policies. Please do not hesitate to contact us with any questions or concerns.

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Privacy Officer: See Office Manager **Effective Date:** April 14, 2003

Notice of Privacy Practices

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 care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

ORAL SURGERY ASSOCIATES OF NORTHERN VIRGINIA, LTD.

PATIENT HIPAA CONSENT FORM

Patient Name:_____ DOB_____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment with Oral Surgery Associates of Northern Virginia.
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice; which may include, disclosing your medical information to personnel involved in your care to include: doctors, nurses, technicians, laboratories, radiology facilities, medical students, medical and dental supply companies (implants, hardware, or materials), and hospital personnel. For example, a doctor to whom we refer you for further care may need your medical record(s), prescriptions, requests of lab work and x-rays. We may discuss your medical information to recommend possible treatment options or alternatives that may be of interest to you. We may disclose your medical information to others involved in your medical care after you leave the Practice; this may include your family members, personal representatives authorized by you or by a legal mandate (a guardian or person named to handle your medical decisions, should you become incompetent).

I have also been informed of and given the rights to review and secure a copy of your Notice of Privacy Practices. which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the rights to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions in writing on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with this restriction.

I hereby authorize Oral Surgery Associates of Northern Virginia, Ltd to use or disclose the protected health information for the above named patient as described below.

The following **person, physician (that is not the patient's general dentist or referring dentist)** or entity may receive disclosure of protected health information for the above named patient:

Name:_____

Relationship to Patient:_____

Contact information:_____

All Dates of Service (unless specified): ( ) specified dates:_____

Oral Surgery Associates of Northern Virginia, Ltd has my consent to leave a detailed message to include financial or medical/dental related information at this :

Email address:_____
I understand that I may revoke this consent, in writing at any time.

Patient or Authorized Signature:_____

Relationship to Patient:_____

Witness Signature:_____

ORAL SURGERY ASSOCIATES OF NORTHERN VIRGINIA, LTD.

Welcome To Our Office

Patient Information

☐ Mr.

☐ Mrs.

☐ Miss

Patient's Name _____

Date of Birth _____ Social Security # _____ - ___ - _____ Home Phone _____

Address _____
Street City State Zip Code

Employer _____ Work Phone _____

Email Address: _____

Emergency contact _____ Relationship _____ Phone: _____

Name of Dentist _____ Primary Care Physician _____

Dentist Phone # _____ PCP Phone # _____

How were you referred to our office? (Check One)

☐ Family Dentist ☐ Family Physician ☐ Friend ☐ Relative ☐ Phone Book ☐ Other

FINANCIAL INFORMATION

Responsible Party _____ Relationship _____ Date of Birth _____

Social Security # _____ - _____ - _____ Phone Number _____

Address _____
Street City State Zip Code

Employer _____ Business _____

Please check method of payment on day of treatment: ☐ Cash ☐ Visa ☐ MasterCard ☐ Check

Insurance: Name of Company _____ Group # _____ ID # _____

TERMS AND CONDITIONS: Financial arrangement must be made in advance. All emergency dental services must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are 1½% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. Additionally, I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signature _____ Date _____

HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Date _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health?..... Y N
2. Has there been any change in your general health in the past year?..... Y N
3. Date of last physical exam.....
4. Are you now under a physician's care for a particular problem?..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe..... Y N

_____

_____

6. Height ..... Weight.....
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic Fever or Rheumatic Heart Disease?..... Y N
   - B. Congenital Heart Disease?..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?)..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing) ?..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily ? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)?..... Y N
   - H. Kidney Disease?..... Y N
   - I. Diabetes ?..... Y N
   - J. Thyorid Disease (Goiter) ?..... Y N
   - K. Arthritis ?..... Y N
   - L. Stomach Ulcers or Colitis ?..... Y N
   - M. Glaucoma?..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee) ? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer?..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth ?... Y N
   - Q. Sinus or Nasal problems?..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - S. HIV/AIDS Autoimmune Deficiency Syndrome..... Y N
8. ARE YOU USING ANY OF THE FOLLOWING :
   - A. Antibiotics?..... Y N
   - B. Anticoagulants (Blood Thinners)?..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications ?..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti- Diabetic drugs ?..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals : _____

     _____

     _____
9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   - A. Local Anesthesia (Novocain, etc.)?..... Y N
   - B. Penicillin or other antibiotics ?..... Y N
   - C. Sedatives, Barbiturates?..... Y N
   - D. Aspirin or Ibuprofen?..... Y N
   - E. Codeine or other pain killers?..... Y N
   - F. Latex or Rubber Products?..... Y N
   - G. Other allergies or reactions? Please, list..... Y N

     _____

     _____
10. Do you Smoke or chew Tabacco?..... Y N
    How much per day?.....
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?..... Y N
12. Have you had any serious problems associated with any previous dental treatment ?..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... Y N
15. Do you wish to talk to the doctor privately about anything?..... Y N
16. FOR WOMEN ONLY
    - A. Are you Pregnant, or is there any chance you might be Pregnant?..... Y N
    - B. Are you nursing?..... Y N
    - C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

Medical Update : I have read my Health History dated.....and confirm that it adequately states past and present conditions.

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

Notice of Deemed Consent for HIV,HBV and HCV Testing

If one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling if necessary.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers or employees in a way that may transmit disease, that person's blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and the person the results of the test and provide counseling if necessary.

Date:_____ Signature_____

(Patient/Parent/Guardian)

Notice of Deemed Consent for HIV,HBV and HCV Testing

If one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling if necessary.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers or employees in a way that may transmit disease, that person's blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and the person the results of the test and provide counseling if necessary.

Date:_____ Signature_____

(Patient/Parent/Guardian)