Elizabeth Mueller, D.D.S. & Associates
Specialists in Children's Dentistry

Patient's Name _____ NickName _____ Age _____
Sex _____ Race _____ D.O.B. _____ Place of Birth _____
Patient's Address _____ Patient's Cell Phone _____
Street City State Zip

Parent #1 _____ DOB _____ Social Security _____
Marital Status: Single Married Separated Divorced Widowed
Address _____ Home Phone _____
Street City State Zip
Email Address _____ Cell Phone _____
Where Employed _____ Work Phone _____
Employer's Address _____
Street City State Zip
Dental Insurance _____
Company Policy Number Group Number Member ID Number
_____
Street City State Zip Phone

Parent #2 _____ DOB _____ Social Security _____
Marital Status: Single Married Separated Divorced Widowed
Address _____ Home Phone _____
Street City State Zip
Email Address _____ Cell Phone _____
Where Employed _____ Work Phone _____
Address _____
Street City State Zip
Dental Insurance _____
Company Policy Number Group Number Member ID Number
_____
Street City State Zip Phone

Stepfather's Full Name _____ Home Phone _____ Work Phone _____
Stepmother's Full Name _____ Home Phone _____ Work Phone _____
Child's Physician _____ Parent's Dentist _____
Whom may we thank for referring you to our office? _____

Health History

Date of your child's last physical _____
Is your child up to date with immunizations? Yes No
Is your child currently undergoing any medical treatment?
If so what? _____
Is your child in speech, occupational or physical therapy?
If so what? _____
Is your child currently taking any medications?
If so what? _____
Has your child ever had a reaction to Latex, Penicillin or any other drugs? _____
Does your child experience canker sores and/or fever blisters? Yes No
Has your child been hospitalized since birth?
_____
Date Reason
Has your child had surgery or general anesthesia?
_____
Date Reason Complications

Check all that apply

- ☐ Heart Conditions
- ☐ Respiratory Problems
- ☐ Epilepsy/Seizure Disorder
- ☐ Craniofacial Problems
- ☐ Bleeding Problems
- ☐ Hepatitis/Liver/Kidney
- ☐ AIDS
- ☐ STD's
- ☐ Allergies/Sinus
- ☐ Cerebral Palsy
- ☐ Anxiety
- ☐ Family history of Anxiety
- ☐ Developmental Delay
- ☐ Autism/Aspergers
- ☐ Mental Retardation
- ☐ Vision Problems
- ☐ Hearing/Ear Problems
- ☐ Speech Problems
- ☐ Sensory Integrations
- ☐ Mental Health Issues
- ☐ ADD/ADHD
- ☐ Learning Problems
- ☐ Pregnant
- ☐ Other _____

If yes to any of above, please detail here _____
_____
_____
_____

Dental History

Purpose of today's visit or chief concern?_____

Is this your child's first dental visit? Yes No

Date of last visit_____

Any previous X-Rays Yes No

Location_____

Who brushes your child's teeth? _____ How Often? _____

Any oral habits (thumb sucking, pacifier, nail biting, etc.)? Yes No

Was your child breast fed? Yes No How long? _____

Was your child bottle-fed? Yes No How long? _____

Is your child going to sleep with a bottle? Yes No

What does the bottle contain: Water Milk Formula Juice Other _____

Has your child had an unfavorable experience in the dental office? Yes No

Explain_____

Have YOU had an unfavorable experience in the dental office? Yes No

Explain_____

Is your water fluoridated? Yes No

Do you have a water filtration system? Yes No

What type? _____

Social History

Is this your biological child? Yes No

With whom does the child live? _____

Are there brothers and sisters in the home? Yes No

Names and Ages? _____

Does your child have an in-home babysitter or go to a babysitter? Yes No

Name? _____

Hobbies? _____

What school, preschool, or daycare does your child attend?_____

Has your child ever repeated a grade? Yes No What Grade? _____

Has your child been in special classes, received an IEP from the state of Ohio, Kentucky, Indiana or a CCDD evaluation?

Behavior Evaluation Parental Questionnaire

My child enjoys swimming. Yes No

My child enjoys getting a haircut. Yes No

My child plays well with other children. Yes No

When exposed to a new situation, my child tends to be shy and timid. Yes No

I expect that my child will be cooperative for dental treatment. Yes No

When I must give liquid medication, my child will swallow it Only if forced Only if coaxed Willingly

I agree to diagnostic procedures and dental treatment as found necessary and explained by Elizabeth Mueller, D.D.S. & Associates for the patient names above. As a parent or guardian of a new patient, I am responsible for my account the day of service. If insurance should not pay within 30 days, I will be billed immediately. Any accounts not paid in full within 60 days will receive a service charge of 1.5% a month. Appointments cancelled without **48 hours** notice will incur a fee.

_____

Date Signature of person legally responsible

Appointment Commitment

You have made an appointment for your child's dental care. In our practice, there are two types of appointments; operative (scheduled with Dr. Mueller or Dr. Goodell), and preventive (scheduled with the hygienist).

All our appointments are in limited supply. Once you have made an appointment, time, trained personnel and dental equipment are reserved specifically for your child's procedure. We respect your time and ask that you respect ours by honoring your appointment commitment. A broken appointment is a loss to everyone, including other children awaiting treatment. For this reason, **it is important that you notify our office at least 48 hours (72 hours for family appointments) prior to the scheduled time if you have to reschedule.** This courtesy enables us to accommodate the needs of your and others children more readily.

We reserve the right to charge for the time reserved if you fail to keep the appointment or cancel with less than 48 hours notice- $50 for operative and $25 for preventive appointments.

Financial Agreement

If we are working with your dental insurance, please remember that your deductible and your initial responsibility (40%) are due at the time of your child's treatment. Because we believe that dental health should be accessible to all patients, our Financial Coordinator is available to discuss the finance options that our office offers.

_____ _____

Parent or legal guardian Date

Elizabeth Mueller, DDS & Associates

9200 Montgomery Rd.
Cincinnati, Ohio 45242

6396 Thornberry Court
Mason, Ohio 45040

CREDIT CARD ON FILE POLICY

At Dr. Elizabeth Mueller & Associates, keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of 2.00 will be added to your account for any balances over 60 days that we must attempt to collect through mailing monthly statement.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Dr. Elizabeth Mueller & Associates to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card Account Number _____

Expiration Date _____ / _____ / _____

Security Code _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Dr. Elizabeth Mueller & Associates to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Dr. Elizabeth Mueller & Associates.
This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Dr. Elizabeth Mueller & Associates in writing and the account must be in good standing.

Responsible Party Name (Print): _____

Signature: _____

Account Number: _____

Date: _____ / _____ / _____

Elizabeth Mueller, DDS & Associates

9200 Montgomery Road, Suite 4B
Cincinnati, Ohio 45242

6396 Thornberry Court, Suite 720
Mason, Ohio 45040

EASY PAY PLAN

Dr. Elizabeth Mueller and Associates is committed to reducing waste and inefficiency and making our billing process as simple and easy as possible. We are now able to keep your HSA card and credit card number on file in our HIPAA-compliant, secure practice management software. This system stores the card information for future transactions, using the same technology an online retailer would. We can't see the card number-only the last 4 numbers, giving us no way to use the card outside of our billing system.

Credit Cards on File will be used to pay account balances after insurance adjudication.

Once your insurance has processed your claims, they will send you an Explanation of Benefits (EOB) showing what your total patient responsibility is. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier and our billing department. If you fail to provide our office with updated insurance and your claim is denied, we will give you a grace period of 45 days from Date of Service to contact our office. If we do not hear from you, the total balance will be billed to your credit card on file.

Easy Pay payments will be processed on or around the 15th of each month. A receipt will be e-mailed to you for your records.

The Easy Pay Plan will help us to cut down on administrative costs. Our staff spends less time on taking credit card information over the phone or entering it from billing slips sent in the mail. (It's much more secure than those options!) We don't have to send out as many statements, which saves trees, money and time. We can spend our time on things we think are more important, like following up with insurance claims, helping patients on the phone and in person, and working to make your visit the best it can be.

First and foremost, it is far more convenient for you! You don't have to call the office or buy a stamp!

If this sounds right for you, please inform our Financial Coordinator, Christine Enneking.

Thank you,

Dr. Elizabeth Mueller and Associates

Elizabeth Mueller DDS and Associates

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

A: Patient Giving Consent

Name of
Patient(s):_____

Address: _____

Telephone: _____ E-Mail (optional) _____

Personal Representative's Name_____

Relationship to patient_____

Personal Representative's Social Security Number_____

Signature_____ Date_____

B: Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices for myself/family.

_____
(Please print name)

_____
(Signature)

_____
(Date)

Elizabeth Mueller, DDS & Associates

INFORMED CONSENT FOR PEDIATRIC DENTAL TREATMENT

One of our most important parental policies is to "inform before we perform." Before we begin treating your child, we ask your permission for periodic dental examinations, x-rays, dental cleanings and fluoride applications. We also need your permission to perform dental treatments, restorations and/or appliances as needed to return all teeth to health and proper function, using local anesthetic and a comfortable mouth prop. The purpose of all these procedures is to gain and maintain dental health, and we expect good results, although no guarantees as to the results may be given.

Although our goal is the best oral health for your child, there are some slight risks involved in getting to that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling and infection. But, ignoring a known dental problem has an even greater risk. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

A visit to the dental office presents the young child with lots of new and unfamiliar experiences. It is completely normal for some children to react to these new experiences by crying. Sometimes they will use stalling behaviors such as asking repetitive questions, asking for non-present parent or stating they need to go to the bathroom. All efforts will be made to gain the confidence and cooperation of our young patients by warmth, humor, gentle understanding and friendly persuasion. High quality dental care for children is our goal. Quality care can be made very difficult or even impossible, by the lack of cooperation.

Behaviors that can interfere with proper dental treatment are hyperactivity, resistive movements, refusing to open the mouth or keep it open, and even aggressive or physical resistance to treatment. Aggressive or physical resistance to treatment can be screaming, hitting, kicking and grabbing the dentist's hands or grabbing our sharp dental instruments. Our goal is to always avoid physical harm to the patient, the parent and our staff members.

There are several behavior management techniques that are used in our office to help children get the quality dental care they need. They are as follows:

A. **TELL-SHOW-DO** is the use of simple explanations and demonstrations geared to the child's level of maturity.

B. **POSITIVE REINFORCEMENT** is rewarding the helpful child with compliments, praise, a pat on the back and gold coins to spend in the Treasure Tower.

C. **VOICE CONTROL** is getting the attention of a noisy child by using firm commands and varying tones of voice.

D. **NITROUS OXIDE (LAUGHING GAS)** The use of laughing gas is another safe way to provide dental treatment to mildly frightened, but helpful children. Laughing gas calms children but does not put them to sleep or numb their

teeth. It has few side effects and last only as long as the gas is being breathed through a nose mask. On extremely rare occasions, the gas can cause an upset stomach and vomiting

E. **PHYSICAL RESTRAINT BY THE DENTAL TEAM** With an active or combative child, it is sometimes necessary for the dental assistant to restrain the child's movement by holding the head, arms, hands or legs. The dentist may restrain the child's head by stabilizing it between arm and body. A tooth pillow may be placed in the child's mouth to prevent closing when the child refuses to open or has trouble keeping the mouth open.

F. **PHYSICAL RESTRAINT BY PARENT** We call this restraint the " Lap-to-Lap" as the "pre-cooperative" child sits on the parent's lap, facing and straddling the parent. The parent and dental team member sit face-to-face and knee to knee forming a bridge. The child lays his head in the dental team member's lap while the parent holds the patient's hands on the patient's belly. This way the child does not have to separate from their parent.

G. **PHYSICAL RESTRAINT BY PEDI-WRAP (BLUE BLANKET)** The use of this type of restraint is a standard of care in medicine. The Pedi-Wrap or Blue Blanket, is the safest and most compassionate way to ensure quality dental treatment of an active child. It holds arms, body and legs secure with Velcro and cloth wraps during treatment. Many times a fearful patient will calm down once they are wrapped in the blanket as they feel "snug as a bug in a rug". THOSE PATIENTS WITHOUT SPECIAL NEEDS WILL OUTGROW THE NEED FOR RESTRAINTS!

Beyond these techniques, a "pre-cooperative" child may need dental treatment with IV Sedation or treatment in a hospital, which is covered in a separate consent form.

I have read and understand this information on behavior management. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate to their age. If any treatment other than the above is needed, it will be discussed with me before beginning such treatment. I understand that I may refuse any or all of the above treatments or procedures. Please speak to the doctor about any of your concerns.

This consent will remain in full force unless withdrawn in writing by the person who has signed on behalf of this minor patient.

_____ _____

PRINT CHILD'S NAME PARENT'S OR GUARDIAN'S SIGNATURE

_____ _____

WITNESS TODAY'S DATE

THANK YOU FOR TAKING THE TIME TO READ AND SIGN THIS IMPORTANT FORM

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Elizabeth Mueller D.D.S. & 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 (4/14/03), 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 you will be charged the following: an initial fee of $15 to compensate for the records search, $1 per page for the first 10 pages of paper record, 50 cents per page for pages 11-50 and 20 cents per page for pages 51 and higher. X-ray duplication will be charged at $5 per duplication. 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, for the last 6 years, but not before April 14, 2003. 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

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 this 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.

Contact Officer: Elizabeth Mueller D.D.S. (owner)_____

Telephone: 513-791-3660_____ Fax: 513-791-3783_____

E-mail: www.drbetsy.net_____

Address: 9200 Montgomery Rd. Suite 4B Cincinnati, Ohio 45242_____