

Benjamin L. Nemec, DDS

6836 Bee Caves Road, Ste. 110 | Austin, Texas 78746 | 512.347.0044 | www.TheHillsDentalSpa.com

Patient History

Patient Name: _____ Birth date: ____/____/____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Social Security #: _____ Driver's License _____
 E-Mail Address: _____

Are you interested in receiving e-mail specials? Yes No
 Would you like to receive a courtesy reminder about your appointment times? Yes No
 If yes, please circle the best way to reach you: Home Phone - Work Phone - Cell Phone - E-Mail

We ask that you provide us with 24 hours notice to change an appointment time. Thank you.

Take your time to accurately complete this form. The information provided will be used as a reference so we may most effectively treat your dental health needs.

Please list any medications you are currently taking, all prescription, over-the-counter medication, vitamins & herbal remedies: _____

Please list drug allergies or allergic reactions you may have (medications, anesthetics, latex, etc.): _____

Have you ever been instructed to pre-medicate prior to your dental appointments? Yes No
 If yes, please explain: _____

Do you currently have, or have you had, *any* of the following conditions?

High Blood Pressure	Y N	Chemotherapy	Y N	Tuberculosis	Y N
Heart Attack/Angina	Y N	Radiation Therapy	Y N	AIDS/HIV	Y N
Mitral Valve Prolapse	Y N	Rheumatic Fever	Y N	STD	Y N
Heart Murmur	Y N	Diabetes	Y N	Hepatitis	Y N
Stroke	Y N	Eating Disorder	Y N	Pregnancy	Y N

Are there any other medical conditions or concerns you would like the doctor to be aware of?

_____ - Patient's Signature _____ - Date



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Office Policy Regarding Payment

Thank you for choosing The Hills Dental Spa. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

The Hills Dental Spa requires payment prior to the initiation of your treatment. If you choose to discontinue care before your sequenced treatment plan is complete, you will receive a refund, less the cost of care received.

For treatment plans requiring multiple appointments, alternative payment arrangements may be provided.

As a courtesy to our clients with insurance, we are happy to provide you an estimate of your specific benefits, as well as to help you file your dental insurance claims at the time of your treatment. We will try our best to assist you in maximizing your available yearly insurance allowance and directly bill them for reimbursement. **Please keep in mind that your insurance contracts only with you and NOT with The Hills Dental Spa, therefore services that are not covered or any balance due after your insurance pays their portion is your responsibility.**

For any returned check, The Hills Dental Spa charges a \$25 plus the bank fee.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I have read and understand the policy stated above and agree to accept responsibility as described. I authorize the release of my dental records and other information required for the processing of all insurance claims. I explicitly understand that I am responsible for the payment of my treatment, regardless of whether or not my insurance accepts or denies payment of a claim.

Signature of Patient or Responsible Party

Date



 THE *Hills* DENTAL SPA

 Cosmetic & Family Dentistry

Name: _____
 Address: _____ City: _____ St: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Occupation: _____ Date of Birth: ____/____/____
 Would you like to receive e-mails about our spa specials? Yes No
 E-Mail Address: _____
 Who may we thank for referring you? _____
 Area of complaint or tension: _____

*The following information will help to anticipate your personal needs.
 Please place a √ in the box to indicate YES to a question:*

- | | |
|---|--|
| <input type="checkbox"/> Have you ever had a professional massage before?
<input type="checkbox"/> Have you ever had a professional skin treatment before?
<input type="checkbox"/> Are you wearing contact lenses?
<input type="checkbox"/> Do you have arthritis or joint disorders?
<input type="checkbox"/> Do you have varicose veins or blood clots?
<input type="checkbox"/> Do you have high blood pressure?
<input type="checkbox"/> Do you have chronic headaches or migraines?
<input type="checkbox"/> Do you have problems sleeping at night?
<input type="checkbox"/> Have you had any significant change in your life recently?
<input type="checkbox"/> Do you exercise or participate in any sports?
If Yes, what kind and how often?
_____ | <input type="checkbox"/> Do you have any skin problems?
<input type="checkbox"/> Do you have allergies? To what?
_____ |
| <input type="checkbox"/> Do you have any heart problems?
<input type="checkbox"/> Do you have spinal problems?
<input type="checkbox"/> Are you pregnant?
<input type="checkbox"/> Is your lifestyle stressful?
<input type="checkbox"/> Do you smoke?
<input type="checkbox"/> Are you on any medications?
If Yes, what kind?
_____ | |

What is your skin condition? Dry Oily Combination Acne Prone
 Please list any medical conditions the therapist should be aware of? _____

During your treatment, the therapist may use Swedish massage, deep tissue technique, aromatherapy, facial massage, myofascial release, reflexology, spa treatments, or other approved techniques to facilitate your treatment. The therapist will massage the necessary body parts to facilitate the massage, excluding any contraindicated areas. The therapist will not work the breast area during your treatment. Proper draping will be used throughout your treatment. If at any time you feel uncomfortable with the massage, the therapist will discontinue treatment. Please notify the spa management immediately if there is anything we can do to make your treatments more comfortable.

Client's Signature _____ Date: _____

Massage therapy is not a substitute for medical examination and diagnosis. It is recommended that I see a physician for any medical ailment that I might have. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. Likewise, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor perform spinal adjustments. Because massage and bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and understand that there shall be no liability on the massage therapist's part should I fail to do so.

Client's Signature _____ Date: _____

Therapist's Signature _____ Date: _____

Benjamin L. Nemec, DDS

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 carefully. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices. Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by 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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make:

Treatment - We will use and disclose your protected health care information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health care information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment - Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations - We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the front desk where you will be asked to sign your name when you arrive. We may also call you by name in the waiting room when your doctor 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.

Business Associates - We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses and Disclosures that May be Made with Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgement to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.

Other Permitted and Required Uses and Disclosures that May be Made without Your Consent

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

Emergencies: We may disclose your health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement of Receipt of Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care.

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 the health or safety of others.

Military Activity and 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 institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

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 Services to investigate or determine compliance.

Your Rights

You have the right to inspect and copy your protected health information. 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 practically do so. You must make the 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 a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you prefer, we will prepare a summary of an explanation of your health information, for a fee.

You have the right to request a restriction of your protected health information. You have the right to request that we place additional restrictions on our use and 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.

You have the right to request alternative communications from us. You have the right to request that we communicate with you about your health information by an 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.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain explanations, restrictions and limitations. 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.

You have the right to make a complaint about our privacy policies. If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the end of this Notice. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this Notice electronically.

I, _____, have received a copy of Dr. Nemeec's Notice of Privacy Practices.
(print name)

Signature

Date: _____

Privacy Practices effective: March 28, 2003

Privacy Officer: Amie Nemeec
Telephone: 512-423-7825 | Fax: 512-347-9844
E-Mail: thehillsdentalspa@mac.com
Address: 6836 Bee Caves Road, Suite 110, Austin, TX 78746

For Office Use Only
Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:
<input type="checkbox"/> Patient refused to sign
<input type="checkbox"/> Communication barriers prohibited obtaining the acknowledgement
<input type="checkbox"/> An emergency situation prevented us from obtaining acknowledgement
<input type="checkbox"/> Other reason: _____

