Welcome to Premier Family Dental!

Thank you for choosing us for you and your family's dental care. We value our patients and believe that excellent communication is essential for you to receive the highest quality dental care. Below you will find information on our office policies. Our team is highly trained and knowledgeable in the clinical procedures we provide and insurance correspondence. As a courtesy, we also provide informative brochures to help you better understand your oral healthcare needs. Please ask one of our team members any questions you may have. We look forward to providing you with top notch, state of the art dental care!

Office Hours and Appointments

Office Hours: Monday-Thursday 8:30am to 4:30pm
Phone Hours: Monday – Thursday 8:30 to 4:30pm; Friday 8:00am to 12:00pm

24 Hour Emergency Line: 512-832-5400 ext 3, leave a detailed message with your name, number, the time you called and a description of your emergency. Your call will be returned within 2 hours. If your call has not been returned within 2 hours, you may contact Dr. Temesgen at 512-699-6532.

Appointment Policy

Our office strives to see every patient at their appointed time. We value your appointment as the opportunity to care for you. In order for us to do that, we ask that you value your reserved time with us. Our office asks that you arrive 10 minutes before your reserved time (unless otherwise specified) so that any accounting or administrative items may be handled prior to your appointment.

If you will be late for you reserved time, please call to let us know. If you are more than 15-minutes late, we will need to reschedule your appointment and there will be a $75 charge for missing your reserved appointment time.

If you are unable to keep your reserved time with us, PLEASE CONTACT US IMMEDIATELY, so that we can provide that time to another patient who is in need of care. Any missed or broken appointments without a 48-hour (2 business days) notice will incur a $75.00/hour failed appointment fee (half-hour appointments will be charged at the hour rate of $75). We ask that if you need to cancel or reschedule your appointment that you follow the cutoff time for contacting us to change your appointment listed below:

Call No Later Than (before appt)	Appointment Day
Thursday at 4:30pm	Monday
Friday at 12:00pm	Tuesday
Monday at 4:30pm	Wednesday
Tuesday at 4:30pm	Thursday
Wednesday at 4:30pm	Friday

If your family's account accrues 3 failed appointment fees, your account will be put on suspension for 1 year during which time you will be unable to schedule another appointment. We reserve the right to terminate the doctor/patient relationship once your family accrues 3 or more failed appointments.

Confidentiality

Your medical information is strictly confidential. We will not release it to anyone without your written consent. A family member may, however, accompany you to your appointments if you wish. If you want a copy of your records sent to another dentist, we will require a written authorization from you. Records will be released to another dentist at no additional charge. Records released to you (the patient) or someone, other than a dentist, authorized by you we incur a $25 processing charge.

Financial Policy

Our fees are based on the usual and customary professional fees for General Dentist in this area of Austin, Tx.

All co-payments and past due balances are due at the time of check-in. If you cannot afford your co-pay or do not bring it with you, your reserved appointment must be rescheduled and a $75 failed appointment fee may apply.

The co-payment collected at the time of check-in is your "ESTIMATED" portion. The co-payment is usually made up of your annual deductible and/or the estimated percentage of treatment your insurance provider is not contributing to. As a courtesy to you, we accept and file most insurance plans at no additional cost.

We accept cash, checks, Visa, MasterCard, Discover and American Express. We offer various interest free financing options through Care Credit. Please ask one our experienced team members for more details on Care Credit as an option for you.

Insurance contribution is a contract between you (the patient) and the insurance company. Therefore, your insurance provider does not guarantee payment of benefits nor can we provide 100% accuracy of the estimated co-payment. Be informed that most insurance companies base their contribution on their own fee schedule and not on the usual and customary fees used to establish our office's fees. Some insurance providers prefer to pay the patient regardless of benefit assignment. In the event that your insurance provider prefers to pay you directly, full payment will be due at the time of service. In the event that your insurance provider does not contribute as estimated, you will be responsible for the balance due. If a credit should result

after insurance contribution, this credit may be applied to future treatment or a formal request for refund may be submitted.

All dental services rendered, whether or not insurance contributes, are ultimately the financial responsibility of the account holder. We will allow your insurance provider 30(thirty) days to remit payment. If no payment has been received at this time, you will be financially responsible for 100% of the outstanding insurance claim. As a courtesy to you, we will retain a copy of your preferred credit card on file for payments. Payment is due no later than the date on the statement sent to you or as indicated upon notification. It will then be your responsibility to follow-up with your insurance provider regarding the non-payment of the claim. Should the insurance provider contribute after you settled the balance on your account, a refund will be issued upon completion of the “Refund Request” form.

Any balances remaining on your account after 60 days will incur a finance charge of 1½% (18% yearly). Balances that reach 90 days past due will be turned over to a collection agency or attorney and you will be responsible for any and all legal fees associated with the collection of this debt. Any account balances must be settled prior to any further treatment. Failure to settle account balances may result in discharge from our practice.

NSF checks will incur a fee of $30 in addition to the amount of the check. The total amount due will have to be paid by cash, cashier’s check, or money order within 10 days of the notification date. Checks that are not taken care of within that time will be turned over to the Hot Check Division at the District Attorney’s office.

Our office will only file your primary insurance. If you also have secondary insurance, we will give you the items necessary to file with your secondary insurance so that they may reimburse you any benefits you may have available. We ask that you inform us 48(forty-eight) hours prior to your reserved appointment if any updates/changes have been made to your insurance provider so that we may verify eligibility. Failure to properly notify us of insurance changes may result in full out of pocket cost for services rendered.

Minor Children

Our office is happy to see all minor patients. All patients under the age of 18 must be accompanied by an adult for the entirety of their appointment. If the adult is someone other than the minor’s custodial parents, a signed release must be on file. The adult bringing the child to their appointment will be asked to pay any co-payments that may be due.

We request that the custodial parent(s) provide a list of authorized adults to accompany the minor to their appointment, discuss matters of their health, and address issues regarding the account. This list may be kept on file for future reference. Anyone not indicated as an authorized guardian for the minor will not be permitted to accompany the minor to their appointment.

Assignment of Benefits

I request that payment be made on my behalf to Dr. Netsanet Temesgen and Premier Family Dental for any services rendered to me by Dr. Netsanet Temesgen and Premier Family Dental.

I authorize the release of medical/dental information about me to my insurer and its agents, any information necessary to determine benefits payable for services rendered.

I hereby authorize and direct my insurance provider to issue payment directly to Dr. Netsanet Temesgen and Premier Family Dental for dental services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not contributed by insurance.

Photo Release

I give permission to Dr. Temesgen and Premier Family Dental to use any photographs or videos taken for the purposes of marketing, website, and educational purposes. I understand that I will not be compensated for the use of photos or videos of me or my dependents nor will I hold Dr. Temesgen or Premier Family Dental liable for the use of these photos and videos.

Authorization to Release Information

I hereby authorize Premier Family Dental to release information regarding my care, discuss my account, review health concerns and health history with the individual(s) listed below. I also authorize the listed individual(s) to make health related and financial decision for my entire family whenever necessary.

Name ____ Phone # __________________

Name ____ Phone # __________________

Name ____ Phone # __________________

Consent

By signing below, I authorize Dr. Netsanet Temesgen or one of her assistants, to take necessary x-rays, photographs, study models or render any other treatment required to give me an accurate diagnosis and customized treatment plan.

Dr. Netsanet Temesgen reserves the right to update and make changes to this office policy at any time without prior notification.

I have read and understand, acknowledge and accept, all policies of Premier Family Dental, and I agree to be bound by its terms. By signing below I acknowledge and accept the office policies of Premier Family Dental.

Patient Name (print):__________________________ Date:____________________________

Patient Signature, Parent or Guardian: ____

Relationship to patient:______________

PREMIER FAMILY DENTAL

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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.

Question	Answer	If yes
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

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

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

Have you ever had any serious illness not listed Yes No If yes

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:

X

Date:__________

Patient Financial Policy

Thank you for choosing us as your dental healthcare provider. We are committed to your care being successful. Please understand that timely payment of your bill is considered part of your care.

To reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policies. You will find this laid out in more detail in your Patient Policy. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibility as an essential element of your care.

_______ As a courtesy, we will bill your insurance provider for all services provided by Premier Family Dental. Because you are a valued patient, we will absorb all costs for billing your insurance provider.

_______ We have made prior arrangements with many insurance companies to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only collect your ESTIMATED payment at the time of service when you arrive for your appointment.

_______ If your insurance provider contributes less than estimated, you will be responsible for the remaining balance. This balance is due upon receipt of notice from our office.

_______ If you have insurance benefits with a plan for which we do not have arrangements to accept assignment of benefits, the full charges for you care are due at the time of service. We will submit the claim on your behalf however, it is your responsibility to follow-up with your insurance provider to get payment reimbursed to you.

_______ In the event that your insurance provider does not reimburse us within 30 days, we will transfer the balance of your account to your credit card, debit, or check card authorized on file.

_______ If care is provided for a minor (child, dependent), we will expect payment from the accompanying adult and the parent or guardian with custody of the minor.

____

Printed Name of the Patient

____ ____________________

Signature of Patient or Responsible Party if a Minor Date

2200 Park Bend Drive Bldg. 1 Suite 200
Austin, Tx 78758
512.832.5400 Ph
512.832.5405 Fax

Credit Card Authorization Form

Card Holder: ______________________________
Billing Address: ______________________________
____

Credit Card Type: __Visa __MC __Amex __Discover __Care Credit __Other

Credit Card Number: ______________________________

Expiration Date: ______________________________

Card Identification Number (last three digits on the back of the credit card): ________

- Copy of Credit Card on File
- Copy of Credit Card holder's Drivers License on File

I,______________________, authorize Premier Family Dental to retain my credit card on file. By signing below, I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize Premier Family Dental to charge my credit card for services provided, products sold, and outstanding balances to my/my family's account. I further agree that if my card becomes invalid, I will provide Premier Family Dental with a new credit card to be charged for payments and outstanding balances. In case of any issues or disputes concerning any transactions, I will first notify Premier Family Dental to rectify the situation prior to notifying my credit card company.

Print Name: ______________________________

Signed: ______________________________

Date: ______________________________

Witness: ______________________________

*Please let us know, in writing, if you would like a courtesy call informing you of the amount charged to your credit card on file.

Effective date of notice: NOVEMBER 1, 2007

NOTICE OF PRIVACY PRACTICES

Netsanet Temesgen, D.D.S.
2200 Park Bend Dr., Building 1, Suite 200, Austin, TX 78758
512-832-5400
512-832-5405

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 respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written

request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

I acknowledge that I received a copy of Dr. Netsanet Temesgen's Notice of Privacy Practices.

Patient name

Signature

Date