

downtown *dental* knoxville

Marsha L Hickey DDS

"Providing Professional and Friendly Dental Care Near Downtown Knoxville"

Welcome to Downtown Dental, and thank you for choosing us to serve your dental care needs. You can relax in knowing you have chosen professionals with a sincere interest in your optimum dental health.

We want your dentistry to be a gentle, positive experience. That's why we strive to provide you with comprehensive, comfortable dentistry. We take all the time necessary to answer your every question and concern. You can relax at Downtown Dental because you are more than just a patient or client. Our goal is to serve you as a friend, in a professional yet caring and comfortable environment.

We offer a variety of services, all designed to give you a beautiful smile and great dental health to last a lifetime. From basic restorative and preventative care to the latest in cosmetic procedures, we are committed to quality dental care and a positive experience.

Dr. Hickey: Dr. Marsha Hickey studied at University/Purdue University Indianapolis, and attended the Indiana University School of Dentistry where she graduated with clinical honors. She is a member of the American Dental Association, Tennessee Dental Association, and the International Association for Orthodontics. Dr. Hickey volunteers her time in the Knoxville community and is involved in programs such as Donated Dental Services and Give Kids a Smile. She has extensive post-graduate education in cosmetic dentistry, including Orthodontics (Invisalign® clear aligners and traditional wire braces).

Our Staff: Each member of our team plays an important role in your care. All staff members regularly attend continuing education courses in order to provide the best possible care to our patients.

Making an Appointment: To schedule an appointment, call 865-524-1655. If for any reason you are unable to keep your appointment, please call our office at least 24 hours in advance. This makes it possible for us to fill your spot with another patient. We reserve the right to charge for no shows.

Your First Visit: For your first visit, please plan to arrive at least 15 minutes early to provide information about your medical history. Please bring any medication information with you so we can enter the information into your records. We also need information about your insurance coverage. Please bring your insurance information with you.

Insurance: Your dental insurance is a contract between you and your insurance provider. As a courtesy to our patients, we will complete and submit the necessary paperwork. Please keep in mind that your insurance may pay all, some, or none of your bill. You are responsible for paying any charges not covered by your insurance. Should you have any questions, concerns, or complaints regarding your coverage, please contact your insurance carrier directly.

Confidentiality: Dental information is confidential and only released with your consent. All of the information that we obtain is important for accurately assessing your dental needs.

Payment: Payment is due at each visit. We accept cash, checks, and most major credit cards. We also offer payment plans at very affordable rates.

Office Hours: Office hours are Monday through Thursday 7:30 – 4:30 p.m.

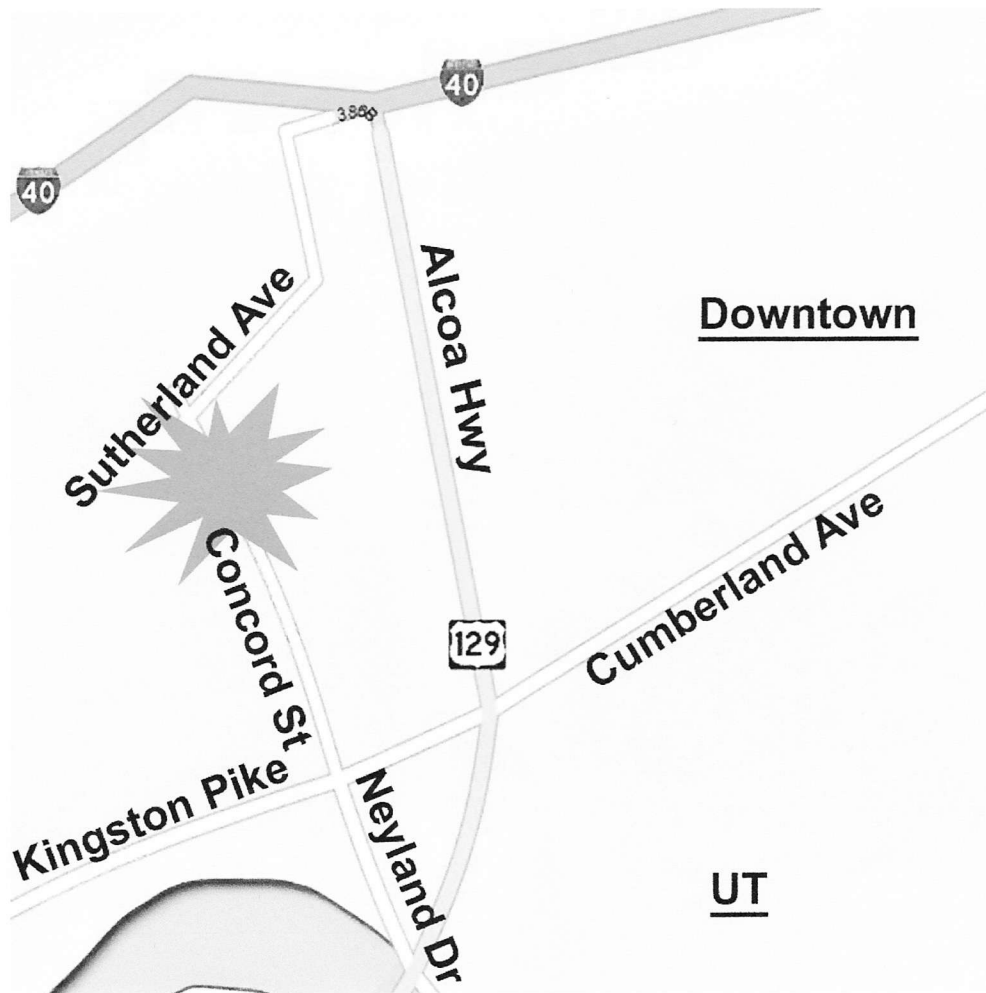
Parking: Free patient parking is available right at our front door, and all around the Cherokee Mills complex.

Satisfaction: We hope this information helps. Keep this brochure handy, and refer to it when necessary. If you have any question or concerns, please don't hesitate to contact us. Your suggestions and comments are always welcome, as your satisfaction is our goal. We look forward to welcoming you to our dental family!

Downtown Dental – Knoxville
123 N Concord Street
Knoxville, TN 37919
865-524-1655

www.DowntownDentalKnoxville.com
office@downtowndentalknoxville.com

We are located on the backside of the Cherokee Mills complex, which is at the corner of Sutherland Avenue and Concord Street. Downtown Dental is just north of the railroad tracks.



PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name _____ Date _____
first middle last

Patient's Birthdate _____ Social Security Number _____ - _____ - _____

SINGLE _____ MARRIED _____ SEPARATED _____ WIDOWED _____ DIVORCED _____

Home Address _____
street city state zip

Home Telephone _____ Cell Phone _____

Work Telephone _____

Patient's Occupation _____ Hours Worked _____

Patient's Employer _____

Business Address _____
street city state zip

Spouse's Name _____
first middle last

Spouse's Birthdate _____ Social Security Number _____ - _____ - _____

Spouse's Occupation _____ Hours Worked _____

Spouse's Employer _____ Work Telephone _____

Business Address _____
street city state zip

In case of an emergency, please contact

Home Phone _____ Work Phone _____ Cell Phone _____

Whom may we thank for recommending you to our office? _____

Who is responsible for this account? _____

PRIMARY COVERAGE

Employee Name _____

Employer _____

Insurance Co. _____

Policy No. _____

Group No. _____

Insurance Co. Phone No. _____

Coverage: Family ☐ Individual ☐

SECONDARY COVERAGE

Employee Name _____

Employer _____

Insurance Co. _____

Policy No. _____

Group No. _____

Insurance Co. Phone No. _____

Coverage: Family ☐ Individual ☐

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I agree to be responsible for payment of all services rendered. I authorize a credit check should I ask for credit.

Patient's Signature _____ Today's Date _____

Medical Dental History Form

Date: _____

Patient Name: _____

Patient ID #: _____

Physician: _____

Premed Required? Yes No

Reason: _____

Type: _____

Dosage: _____

Allergic to:

Latex: Yes No

Medications: _____

Other: _____

Current Medications: prescription, over the counter, and herbal

Medication	Dosage	Frequency

Attach list if more medications are taken

Past and Current Medical Conditions: Mark all that apply

YES		YES	
Under physician's care		Lung disease	
Details:		Emphysema	
Hospitalization/operation in last 5 years		Shortness of Breath	
Details:		Asthma	
		Sleep Apnea	
Head/neck/mouth injuries		Tuberculosis	
Women: pregnant		Sinus trouble	
Woman: nursing		Cancer	
Woman: oral contraceptives		Radiation treatment to head/neck	
Heart trouble/disease		Chemotherapy	
Rheumatic fever		Kidney disease	
Mitral valve prolapse		Dialysis	
Heart surgery		Eating Disorder	
Artificial heart valves		Stomach: reflux or ulcer	
Pacemaker		Immunological disease	
Indwelling defibrillator		Sjogrens Disease	
Artificial joints		Fibromyalgia	
History of Organ Transplant		Other autoimmune disease	
High blood pressure		(Lupus, pemphilus)	
BP:		Arthritis or joint disorder	
Stroke		Diabetes: Type: controlled? Y N	
Bleeding problem		Headaches	
Hemophilia		Depression: Diagnosed? Y N	
Anemia		Other psychiatric disorders	
Leukemia		Neurologic Disease	
		Convulsions/Epilepsy/Seizures	

TURN OVER PLEASE

Past and Current Medical Conditions: Mark all that apply

YES

Fainting/dizziness	
Cerebral Palsy	
AIDS/HIV positive	
Alcohol or chemical dependency	
Hepatitis: Type A B C	
Thyroid disease	
Glaucoma	
Tobacco use: Type: Amount: If quit, what year:	
Mouth odors/bad taste	
Dry mouth/excessive thirst	
Sensitive teeth? Hot or cold or pressure or sweets	
Cold sores/blisters/oral lesions	
Are you aware of any lumps or swellings	
Frequency of flossing:	
Sore , bleeding gums	
Use fluoridated toothpaste	
One or more fillings in the last three years	
Family history of extensive decay	
Have you had orthodontics (braces)	
Have you had oral surgery	
Have you had any dental implants placed	
Treatment for tempormandibular disorder (TMD or TMJ)	
Do you wear a denture or partial denture	

Previous dentist:	
Last cleaning:	
Last visit if not cleaning:	
Primary source of drinking water: circle City water At home filtration Bottled water Well water	
How many soft drinks do you drink in a day:	
Frequency of brushing:	
What are some typical foods you eat between meals?	
What types of beverages do you typically drink between meals?	

Sign and date _____



Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Financial Policy for Our Patients

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I realize that failure to keep this account current may result in you being unable to provide additional dental services and may require prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balance.

Signature

Date

Our office wants all our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits your needs:

Insurance: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, you will be asked to pay your deductible and your copayment for charges on the day the service is rendered. We will estimate as closely as possible your coverage, **but we can make no guarantee of any estimated coverage.** Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the total balance.

Payment Options:

1. **Cash or Check**
2. **Credit Card-** Visa, MasterCard, Discover, and American Express
3. **Care Credit** – This is a medical credit card with an outside financing company that can be applied for through our office or website. The application is filled out and within minutes, we will know if it is approved or not. They offer interest free payments for up to 18 months.



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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2011, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

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

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you \$2 for each page, \$10 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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: Susan Keith

Telephone: 524-1655 Fax: 546-3797

Address: 123 N Concord Street Knoxville, TN 37919