BayView
ORTHODONTICS
FOR CHILDREN AND ADULTS

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS
AAO American Association of Orthodontists

Dr. J. Austin Rahaim, DMD, MS
101 Reese St., Bay St. Louis, MS 39520
(228) 467-2211
www.bayviewortho.com

Patient Privacy Practices (HIPAA) Summary
Patients First: How We Protect Your Privacy

At BayView Orthodontics, we are committed to providing you with the highest quality of care. An essential part of this commitment is our dedication to protecting the privacy and the confidentiality of your medical information.

Our patient privacy pamphlet has been prepared in response to federal regulations that enforce the Health Insurance Portability and Accountability Act of 1996, which is known by the acronym HIPAA. More recent regulations, effective April 14, 2003, set forth certain legal requirements regarding how healthcare providers must protect your medical information. To comply, our office must provide you with a Notice of Privacy Practices, which describes how your medical information may be used and disclosed. This notice also discusses your rights a as patient under the law.

We encourage you to read the information in its entirety. It will explain how BayView Orthodontics may use and disclose your medical information and it will help you understand your rights as a patient. For your convenience, what follows is a summary of key provisions of this notice.

BayView Orthodontics may use and disclose your medical information to:

- Medical staff and personnel who provide you with care.
- Remind you about an appointment.
- Talk to family or friends involved in your care.
- Ensure that we follow the rules of regulatory agencies regarding quality of care and effective us or resources.
- Comply with legal requirements, subpoenas or court orders for mandatory reporting, such as with cases involving child or elder abuse.
- Research personnel as they develop and seek out the best possible treatments for diseases and medical conditions. All researchers must follow specific regulations to ensure the privacy or patient information.
- Tell you about care-related benefits or services that may be of interest.
- Request payment from your insurance company.
- Your medical record is the physical property of BayView Orthodontics, but the information contained in the record belongs to you. You have important rights concerning your medical information.

You have a right to:

- See and obtain a copy of the medical information used to make decisions about your care.
- Ask us to amend the medical information we have about you, if you feel the information we have is wrong or incomplete.
- Ask us to restrict or limit the medical information we use and share about you.
- Ask us to communicate with you about medical matters in a certain way or location.
- Obtain a list of individuals or entities that have received your medical information from BayView Orthodontics for reasons other than treatment, payment, or healthcare operations.
- Submit a complaint.

If you have any questions or would like to report a concern or problem regarding the handling of your medical information, please contact our office at (228) 467-2211.

Sincerely,
BayView Orthodontic Staff

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

(Patient Name) _____ has received a copy of this office's Notice of Privacy Practices.

_____
Please Print (Patient/Parent/Guardian)

_____
Please Sign (Patient/Parent/Guardian)

_____
Date

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

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (specify _____)

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Patient Information

Date _____

Patient's Last Name _____ First Name _____ Middle Initial _____

Address _____

Home/Cell Phone _____ Birthdate _____ SSN _____

If patient is a minor, parent or guardian's name _____

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

Responsible Party Information

(If patient is under 18 years of age *or* patient is under a family member's insurance policy)
Must enter 2 phone numbers that patient/parent/guardian can be reached

Last Name _____ First Name _____ Middle Initial _____

Address _____

Home/Cell Phone _____ Birthdate _____ SSN _____

Email Address _____ Employer _____

Spouse's Name _____ Employer _____

Home/Cell Phone _____ Birthdate _____ SSN _____

Emergency Contact (not a person listed above)

You must provide phone number for emergency contact

Name of nearest *relative or friend* not living with you _____

Address _____

Relationship _____ **Phone No.** _____

Dental Insurance Information

Please provide receptionist with card to make copy

Insured's Name _____ SSN _____

Insurance Company _____ Policy No. _____ Group No. _____

Do you have dual coverage (more than one dental insurance)? Yes _____ No _____ If yes:

Insured's Name _____ SSN _____

Insurance Company _____ Policy No. _____ Group No. _____

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Medical History

Regular Physician _____ City _____

Physician's Office Phone Number _____ Month of Last Visit _____

List Medications: _____

_____

List ALL Allergies: _____

List Medical Conditions (such as epilepsy, diabetes, asthma, anemia, heart murmur, etc.) _____

_____

_____

Dental History

General Dentist _____ City _____

What concerns you about teeth? _____ Month of Last Visit _____

Yes	No	Currently experiencing dental pain
Yes	No	Ever lost or chipped teeth
Yes	No	History of facial or oral injuries
Yes	No	Teeth sensitive to heat or cold
Yes	No	Teeth sensitive to pressure
Yes	No	Gums bleed excessively
Yes	No	History of thumb sucking
Yes	No	Ever seen an orthodontist
Yes	No	Sore jaw when waking up
Yes	No	Teeth grinding
Yes	No	Chronic ear ringing
Yes	No	Ever taken bone density medicine
Yes	No	Currently pregnant or breastfeeding

Benefits

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for education and promotional purposes. I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. J. Austin Rahaim, DMD, MS, to perform a complete orthodontic evaluation.

Signature _____ Date _____

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BayView Orthodontics Photo Consent Form / Release

Patient's Name _____

BayView Orthodontics on occasion takes photos and videos of patients to be used in the offices, on the BayView Orthodontics website, Facebook, news print, and related publications. This list is not inclusive but serves to demonstrate situations in which patients may be photographed or filmed.

To see your or your child's photos, you can add our Facebook page, **www.facebook.com/bayviewortho**

CHECK ONE BOX ONLY:

_____ I DO give permission to BayView Orthodontics to display the patient's photo(s) or video(s) in associate with BayView Orthodontics events, functions, or publications.

_____ I request that my photo or video NOT be displayed in association with BayView Orthodontics events, functions, and publications.

Signature of PARENT or legal guardian (if under 18)

_____

Signature of PATIENT (if over 18)

_____

Date _____