American Association of Orthodontists®
My Life. My Smile. My Orthodontist.®

CONFIDENTIAL

Medical Dental History Form for Adult Patients

Patient

Date _____

Patient's last name _____ First name _____ Middle initial _____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____

Birth date _____ Sex ☐ Male ☐ Female Social Security # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address _____ City, State, Zip code _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Email Address(es) _____

Occupation _____ Employer _____

Closest Relative

Spouse or closest relatives name(s) _____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____

Address *(if different than patient address)* _____

Home Phone *(If different)* ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Dentist

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

Physician

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

General Information

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe. _____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

_____

Financial Responsibility

Who is financially responsible for this account? _____

Address *(if different than page 1)* _____ City, State, Zip _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Email address(es) _____

Social Security # _____ Employer _____

Dental Insurance

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Medical Insurance

Policy holder's full name _____

Insurance Company _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

Medical History

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Do you eat a well-balanced diet?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following?

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances _____

Dental History

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Bleeding gums, bad taste or mouth odor?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ "Gum boils," frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Food impaction between the teeth?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Abnormal swallowing (tongue thrust)?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Ringing in ears, difficulty in chewing or opening jaw?
- ☐ ☐ ☐ Have you ever been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Have you ever been diagnosed with gum disease or pyorrhea?
- ☐ ☐ ☐ Have you ever had an orthodontic consultation or treatment before now?

Patient Health Information

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe._____

_____

Do you take antibiotic pre-medication before any dental procedures? _____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

Family Medical History

Have your parents or siblings ever had any of the following health problems? If so, please explain._____

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

_____

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____

Medical History Updates or Changes

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

HIPAA PRIVACY FORM

Notice of Privacy Practices

Purpose: This form presents the information that federal law requires us to give our patients regarding our privacy practices.

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 January 1, 2016. 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.

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 January 1, 2016 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 that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 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 having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders via voicemail messages, emails, text messages, or letters to your home address.

Patient Rights

Access: You have the right to look at or obtain 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 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 may 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 an alternative format, we may charge a cost-based fee for providing your health information in that format. If you prefer, we can also prepare a summary or explanation of your health information. 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 January 1, 2010. 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. 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, you are entitled to receive this Notice in written form should you request it.

Questions and Complaints

If you would like more information about our privacy practices or have questions or concerns, please contact us.

We also encourage you to contact our office if you feel that any of the following have occurred:

- You are concerned that we may have violated your privacy rights.
- You disagree with a decision we made about access to your health information.
- You disagree with a decision we made in response to your request to amend or restrict the use or disclosure of your health information.
- You disagree with a decision we made in response to a request you made to have us communicate with you by alternative means or at alternative locations.

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: Michael J. Erhart, DDS
Address: 1879 Bay Scott Circle, Suite 108, Naperville IL 60540
Telephone: 630-357-9800
Email: office@erhartorthodontics.com

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices & Disclosure Permission

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Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

Acknowledgement of Receipt of Notice of Privacy Practices

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* You may refuse to sign this acknowledgement

I, _____, have received a copy of Erhart Orthodontics' Notice of Privacy Practices.

_____

Patient's Signature

_____

Date

Disclosure Permission

I, _____, grant Erhart Orthodontics, P.C. permission to discuss my health information with the following individuals:

_____	_____
Name	**Relationship to Patient**
_____	_____
Name	**Relationship to Patient**
_____	_____
Name	**Relationship to Patient**

Further, I give Erhart Orthodontics, P.C. permission to leave voicemail messages containing patient information at the following phone numbers:

_____	_____
Phone number	**Contact name/Relation**
_____	_____
Phone number	**Contact name/Relation**
_____	_____
Phone number	**Contact name/Relation**

_____

Patient Signature

_____

Date

Erhart Orthodontics
MICHAEL ERHART DDS

Office Policies Regarding Insurance

Erhart Orthodontics, P.C. is not contracted with any insurance companies. We will however submit claims to your insurance company on your behalf. Payment in full is due from the patient and ***all insurance payments made on treatment will be sent directly to the subscriber***.

Please note that your financial contract with our office does not always correlate with how your insurance will make reimbursement payments. Most insurance companies follow a formula to determine reimbursement regardless of how you are making payments to our office (normally on a monthly basis per our "Contract for Orthodontic Treatment").

Most dental insurance policies will pay a *lifetime* maximum on orthodontic treatment. However, orthodontic insurance is NOT reimbursed in one lump sum and most insurance companies pay out at a percentage each month or quarter until the lifetime maximum has been met. We will check your insurance benefits prior to beginning treatment and inform you of your coverage to the best of our ability.

Please help us manage your insurance submission by doing your part. In order to ensure you get the most out of your insurance benefits, **it is your responsibility to**:

- ***Make sure you receive your reimbursement payments***

  Most documentation is sent only to the subscriber, so it is your responsibility to inform us if you are not receiving your payments properly. In addition, if you receive notification that additional information is needed from our office, it is your responsibility to provide us with a copy of the documentation so that we can provide them with the necessary information.

- ***Save all Explanation of Benefits (EOBs) from your insurance company***

  Until treatment has been completed, we ask that you save all documentation you receive from your insurance company. In the event that your insurance changes mid-treatment, your new insurance company may require these documents as proof of how much was previously paid on treatment.

- ***Notify Erhart Orthodontics of any changes to your insurance policy (ex: change of insurance company, change of employer, etc.)***

  We are happy to submit to your new insurance policy or company, but it is your responsibility to notify us when the change occurs (within 90 days of the change).

  NOTE: if you had previous coverage, you will also need to provide us with copies of all orthodontic EOBs from your previous insurance company so we can submit these with the claim to your new insurance!!! Failure to do so may result in non-payment of benefits from the new insurance company.

- ***Contact your flexible spending (FSA) or health savings (HSA) account provider to verify their policies***

  For privacy reasons, FSA and HSA administrators will only speak directly with the benefit holder. Therefore, if you are using either of these account types to pay for treatment, it is your responsibility to understand the guidelines regarding whether or not it is acceptable to do so if your insurance company is also reimbursing you. We are happy to provide you with detailed receipts for you to submit to your flex or health savings provider.

Date: _____

Please fill out all of the information below regarding your **DENTAL** insurance. We do not need any medical insurance information.

Primary Insurance:

* Dental Insurance Company _____

* Address_____

* City_____ State_____ Zip _____

* Dental Insurance Company Phone Number_____

* Policy Holder's Name_____

* Policy Holder's Date of Birth_____

* Policy Holder's SS or Member ID # _____

* Group Number_____

* Employer's Name_____

* Address_____

* City_____ State_____ Zip_____

* Employer's Phone Number_____

If you have any questions and or concerns please feel free to contact our office.

Thank you,

Dr. Erhart and Staff

* REQUIRED FIELDS – We must have complete information in order to check and submit insurance claims on your behalf.

Erhart Orthodontics
MICHAEL ERHART DDS

Appointment Policies

OFFICE HOURS

Our office is open for patient care Monday through Thursday. Office hours vary slightly from day to day, but we are generally in the office from 8am until 4:30pm. Summer office hours may also vary. The office is closed on Fridays for administrative tasks.

MISSING SCHOOL/WORK FOR APPOINTMENTS

We understand that our patients have priorities beyond their orthodontic treatment (work, school, sports, etc.) and that it can sometimes be difficult to make time for appointments. We do our best to accommodate afterschool/after work appointment requests, but there will be times when it is necessary to miss school or work. The majority of appointments will be routine "adjustment" visits (typically done every 4-8 weeks) and these can generally be done during afternoon hours. If you or your child needs to miss school or work for an appointment, we will gladly provide you with an excuse slip confirming your appointment with us.

Examples of appointments that will be scheduled during the school or work day are:

- **Appointments to monitor dental eruption and check retainers.** Patients scheduled for these appointments are generally seen every 4-12 months and there is currently no charge for these visits. These appointments are scheduled Monday through Thursday at 2:30 and 2:45pm during the school year. Summer hours vary slightly (appointments available during early afternoon).
- **Longer visits such as taking records, placing and removing braces, making new retainers, etc**. These appointments are more detailed and technique-sensitive so they are scheduled during our quieter morning hours.
- **Repair appointments**. When brackets, wires, or other orthodontic appliances become broken, repairs may require additional time beyond what is set aside at normal adjustment appointments. In order to keep treatment progressing appropriately, we may ask that you schedule an appointment during morning hours for the repair.
- **Rescheduled "adjustment" appointments**. Adjustments are typically scheduled 4-8 weeks in advance. Therefore, it may be unlikely that an afternoon appointment is available if an appointment needs to be rescheduled within a few weeks of the visit. We may ask you to take an earlier appointment in order to keep treatment on track. We also have a cancellation list that you can request to be placed on so we can offer other appointments that become available. ***NOTE: effective December 1, 2014, missed appointments or those cancelled within 24 hours of the appointment time will incur a $40.00 charge that must be paid prior to the next visit.***

NOTE REGARDING DAYS OFF SCHOOL

Because the vast majority of our patients are school-aged, days off school fill very quickly (sometimes months in advance). Therefore, we cannot guarantee appointments will be available in the time frame you or your child needs to be seen on these days. If you are interested in appointments on days off, please let us know as soon as possible so we can check our availability.

BROKEN BRACKET/APPLIANCE POLICY (ex: brackets, wires, retainers, etc.)

Routine adjustment appointments do not generally allow enough time to address broken appliances. Therefore, we ask that broken brackets, loose bands or broken appliances/retainers be called in prior to your appointment. Based on your treatment status, we will determine the urgency in addressing the situation and schedule accordingly. In order to keep treatment progressing appropriately, we may ask that you schedule an appointment during morning hours for the repair.

If a patient arrives for his/her regular appointment with a broken appliance that we were not notified of, we may need to reschedule the appointment to allow for additional time. This helps us run on time in fairness to all of our patients and ensures that we will be able to help you when you are here for appointments.

SCHEDULING OF NEXT APPOINTMENTS

In order to keep treatment progressing as quickly as possible, we suggest you schedule follow-up appointments ***at the time of your previous appointment***. The normal interval for seeing patients is 4-8 weeks, so our schedule is generally booked out that far. Therefore, it can be difficult to get an appointment in the time frame you/your child needs to be seen if you wait to schedule.

LATE ARRIVALS

Our office makes every attempt to remain on schedule throughout the day. We value your time and will do our best to keep you from having to wait. Late arrivals will be worked into the schedule if time allows or may be rescheduled to another day in fairness to other patients. Please call us if you know you will be running late, so we can potentially save you a trip to the office just to reschedule.

CONFIRMATION OF APPOINTMENTS

As a courtesy, we have an automated e-mail system that sends out appointment reminders 2-3 days prior to your visit. However, we do ask that patients/parents assume responsibility for their appointment time even if they do not receive an e-mail reminder. It is also your responsibility to keep us updated on any changes to your e-mail address so you can be sure to continue receiving e-mails from our office.

AFTERHOURS CARE

There are very few true emergencies in orthodontics. However, in the event that a problem with your braces causes *extreme* discomfort or an inability to eat or talk, emergency afterhours coverage is available. Our emergency phone # is 630-995-1311. When the office is closed, an assistant is available M-Th from 8am to 7pm, F from 9am to 5pm and Sat/Sun from 9am-12pm. If your call is unanswered during these hours, please leave a message. If you require immediate attention outside of these hours, please visit your local emergency room.

Acknowledgement of Receipt and Acceptance of "Appointment Policies"

_____
Signature

_____
Printed Name

_____
Date

AUTHORIZATION TO EMAIL
PROTECTED HEALTH INFORMATION

Patient Name: _____ Patient's DOB: _____

Although secure electronic messaging is preferred, unsecure email communication containing sensitive health information may at times be sent between Erhart Orthodontics, P.C. and our patients. By signing this form, a patient (or minor patient's guardian) authorizes Erhart Orthodontics, P.C. to transmit information to him/her via email and agrees to the following:

• I understand that any email transmission between my provider and me/the patient will become part of my medical record. These email transmissions may be disclosed in accordance with future authorizations.

• I understand that I have the right to revoke this Authorization at any time by indicating so below. If I wish to revoke authorization, I understand that I must do so in writing and that the revocation will not apply to any information already previously released as a result of a prior Authorization.

• I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that Erhart Orthodontics, P.C. cannot deny or refuse to provide treatment if I refuse to sign this Authorization.

• I understand that, once information is disclosed pursuant to this Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

☐ **Authorize email communication**

I authorize Erhart Orthodontics, P.C. to email me information including, but not limited to, details of orthodontic treatment, appointment scheduling and financial matters.

Patient/Parent's email address (please print): _____

☐ **Change email address**

I am changing the email address to be used for communications with Erhart Orthodontics, P.C.

New email address (please print): _____

☐ **Discontinue email communication**

I no longer wish to communicate via email.

I have read and understand the Authorization to Email Protected Health Information and the following Alert for Electronic Communications and authorize Erhart Orthodontics, P.C. to email messages possibly including protected health information about me / the patient, whenever necessary.

_____ _____

Patient/Guardian's signature Today's date

Alert for Electronic Communication

Patients and/or personal representatives who wish to communicate with their health care providers by email should consider all of the following issues before signing an Authorization to Email Protected Health Information:

1. Email at Erhart Orthodontics, P.C. may be forwarded, intercepted, printed and stored by others beyond the knowledge and control of Erhart Orthodontics, P.C.

2. Email communication is a convenience and is not appropriate for emergencies or time-sensitive issues.

3. Highly sensitive or personal information should only be communicated by email at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).

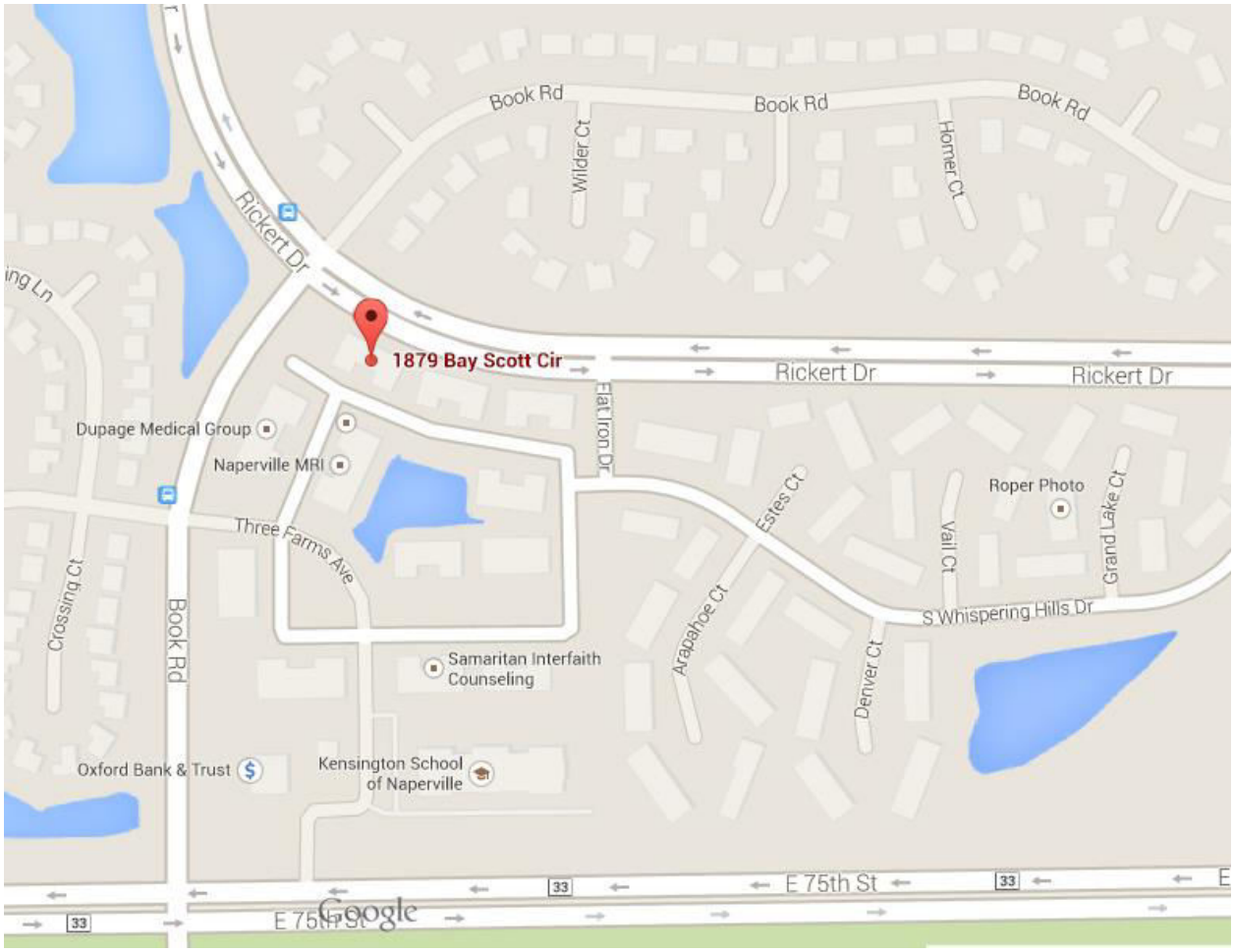
4. Employers generally have the right to access any email received or sent by a person at work.

5. Staff members other than Dr. Erhart may read and process email.

6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.

7. Erhart Orthodontics, P.C. will not be liable for information lost or misdirected due to technical errors or failures.

Erhart Orthodontics
1879 Bay Scott Circle
Suite 108
Naperville, IL 60540
Office phone #: 630-357-9800



We are located:

South of Rickert Drive
North of 75th Street
East of Book Road

From Book Road turn EAST on to Three Farms Ave.
Take your first LEFT, which is Bay Scott Circle.
You will see our building **straight** ahead of you.
Each building has a Suite 108 so be sure to find our building (1879).