

ANTHONY J. TISONCIK, DDS

WELCOME TO OUR PRACTICE

On behalf of the entire team at Anthony J. Tisoncik, DDS, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequalled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History Questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.HickoryHillsDental.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Anthony J. Tisoncik, DDS

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ANTHONY J. TISONCIK, DDS

(708) 599-2929

8071 West 95th Street
Hickory Hills, IL 60457

www.HickoryHillsDental.com

Your complete oral health is our main concern. Communication is key to helping us give you a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____

APT / CONDO #

CITY STATE ZIP

Single Married Divorced Widowed Separated

Home #: (____) _____ Pager/Cell #: (____) _____

Work #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

(please circle)
Last Visit Date: _____

2 SPOUSE INFORMATION

Name: _____

Employer: _____

Work #: (____) _____ Ext: _____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account:

Work #: (____) _____ Ext: _____ Home #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Work #: (____) _____ Home #: (____) _____

4 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please Explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: Good Fair Poor

Are you taking any prescription, over-the-counter, or supplement drugs?
 Yes No

Please list each one: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate? Yes No

Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

- | | |
|---------------------------------------|----------------------------------|
| Y N Anemia/Radiation Treatment | Y N Hemophilia/Abnormal Bleeding |
| Y N Artificial Bones/Joints/Valves | Y N Hepatitis |
| Y N Arthritis | Y N High/Low Blood Pressure |
| Y N Asthma | Y N HIV+/AIDS |
| Y N Blood Transfusion | Y N Hospitalized for Any Reason |
| Y N Cancer/Chemotherapy | Y N Kidney Problems |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Diabetes | Y N Psychiatric Problems |
| Y N Difficulty Breathing | Y N Rheumatic/Scarlet Fever |
| Y N Drug/Alcohol Abuse | Y N Severe/Frequent Headaches |
| Y N Emphysema/Glaucoma | Y N Shingles |
| Y N Epilepsy/Seizures/Fainting Spells | Y N Sickle Cell Disease/Traits |
| Y N Fever Blisters/Herpes | Y N Sinus Problems |
| Y N Heart Attack/Stroke | Y N Tuberculosis (TB) |
| Y N Heart Murmur | Y N Ulcers/Colitis |
| Y N Heart Surgery/Pacemaker | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

- | | | |
|------------------------|--------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Jewelry/Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex | Y N Other |

Please list any other drugs/materials that you are allergic to: _____

5 DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Hard Medium Soft

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____

ANTHONY J. TISONCIK, DDS

PATIENT REFERRAL PROGRAM

We want to help you and your friends receive the best possible dental care available. There are so many exciting new materials and techniques to restore teeth that most people don't know exist. We value good people, as we are sure you do, too. We still have space available for new patients in our office, and we would like to offer to anyone you know who would value quality dentistry the opportunity to receive a special free dental consultation for new patient care.

For every patient that you refer to this office for dental care, we will credit your account with \$25.00. Consider this a thank-you courtesy to be used towards any dental service that we provide! All that we ask is that you refer an individual outside of your immediate family who values quality dental care and personal attention. The greatest compliment you can pay us is by referring someone close to you.

Anthony J. Tisoncik, DDS

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FINANCIAL MENU

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you, regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options and welcome your suggestions and questions.

A) Split Payment

Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

B) Pre-Authorized Credit Card Agreement

With your permission and signature, we will charge your Visa, MasterCard, American Express, or Discover with an agreed payment amount each month. This allows you to make monthly payments without applying for additional credit.

C) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

D) Prepayment in Full (For treatment over \$2000)

A prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

E) Chase Health Advance Plan

With fast approval over the phone from Chase Health Advance, your payment can be much lower than those available through our office. Chase Health Advance specializes exclusively in helping patients with larger dental cases to receive the treatment they want. Chase Health Advance carries fixed rates and can extend terms out to 60 months. There is no prepayment penalty. We will assist you in contacting them from our office.

F) Gradual Treatment Plan

FOR THOSE PATIENTS ON A LIMITED BUDGET. By prioritizing treatment, those patients who do not have dental insurance or are on a tight budget can still complete their dental work by spreading appointments over several months or years.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks, or Chase Health Advance Plan (see above).

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

I certify that I have read, fully understand, and accept the above financial policy.

Signature: _____ Date: _____

ANTHONY J. TISONCIK, DDS

SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS

At Anthony J. Tisoncik, DDS, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits, but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't, we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits...

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits, please contact your employer or the benefits carrier directly.

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of \$1,000. There has been no significant increase in the yearly maximum cap in 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." A dental benefits company determines their reimbursement level by surveying a geographical area and calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that dental benefit companies define as "*higher than usual and customary.*"

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum, or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Dental benefit companies do NOT cover many routine and newer dental services.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.

ANTHONY J. TISONCIK, DDS

Our office is pleased that you have insurance benefits to help you with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept all private care insurance (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?

We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to visiting our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DIDN'T PAY. NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

Our office does request payment in full for your estimated portion at the time of service. If you are in need of an extended option, please just ask one of the patient services staff for an application.

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NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature: _____ Date: _____

Please contact us for more information:
Anthony J. Tisoncik, DDS
8071 West 95th Street
Hickory Hills, IL 60457
(708) 599-2929
www.HickoryHillsDental.com

For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 or Toll Free: 1-877-696-6775