



Patient Appointment Information

Welcome and thank you for choosing the East Carolina University School of Dental Medicine for your oral health care needs. We are committed to providing you with the best possible service and appreciate the trust you have placed in our team of professionals. It is important for you to understand and agree to the following information so as to avoid any misunderstanding about our appointment policies.

The Dental School will only allow two failed/broken appointments before action is taken. A failed or broken appointment is defined as:

- Not showing up for your reserved appointment time.
- Arriving more than 15 minutes late for your reserve appointment without prior notification

If you fail two appointments as defined above, you will not be allowed to reserve future appointment time and your record will be placed in our inactive file. You will be allowed to visit our emergency clinic on an as needed basis.

Important Reminders About Your Appointment:

Appointment Confirmation: It is critical that we are able to confirm your appointment before the scheduled date since many appointments are reserved weeks in advance. We will attempt to contact you two working days in advance of your scheduled appointment utilizing your preferred method of communication. You are ultimately responsible to be available to communicate directly with us to confirm all appointments. Appointments that are not confirmed by noon the working day before the reserved time may be cancelled and another patient offered that appointment opportunity.

Check-in: Please arrive 15 or more minutes in advance of your reserved appointment time and be sure to check-in with the receptionist upon your arrival. A valid driver's license or photo ID must be presented at each visit along with any insurance information/verification of coverage.

Checkout: Please be sure to check out at the reception desk in order to pay for services rendered and schedule your next appointment.

Insurance: If you have dental insurance, please bring documentation and present it to the receptionist at the time of check-in for verification of coverage/eligibility at each appointment. We also ask that you supply us with any written plan information you have been given by your employer so that we may help maximize your insurance benefits.

Financial: All accounts must be current. Patients with past due account balances (greater than 30 days) will not be allowed to schedule appointments.

Rescheduling/Canceling an Appointment: In the event you need to reschedule or cancel a reserved appointment, please contact our office. We will alert your dental provider of any changes in your appointment status immediately.

Financial Policy Information

Welcome and thank you for selecting the East Carolina University School of Dental Medicine as your dental provider. We are committed to providing you and your family with the best possible service and appreciate the trust you have placed in our team of professionals. Before we perform any service, an explanation of the recommended treatment, treatment options, and a reasonable estimate of treatment fees will be presented to you for your approval. We ask that you carefully review and sign our Financial Policy Agreement before beginning treatment and encourage you to communicate with us regarding any problems that may affect your ability to afford care.

Payment for Services:

Payment is expected at the time service is rendered unless other financial arrangements have been made in advance with a Clinic Administrator. This includes any insurance, Medicaid, or other third-party deductible or co-payment. We accept cash, personal checks, money order, and most major credit cards.

Dental Insurance:

The ECU School of Dental Medicine accepts most dental insurance plans. As a courtesy, we will file your dental insurance claim form assuming you have assigned benefits to the ECU School of Dental Medicine. Please contact your insurance company or consult your certificate of coverage for details pertaining to deductibles, co-payments, annual maximum, covered/non-covered services, plan restrictions, and your insurance plan participating or non-participating relationship with the ECU School of Dental Medicine.

You are asked to bring a copy of your insurance card or verification of coverage to each appointment.

Your insurance policy is a contract between your employer and the insurance company and as such we are not a party to that contract. Our relationship is with you, the patient, and not the insurance company and therefore you or your account guarantor is ultimately financially responsible for all services rendered including services that are not covered by your policy. If your insurance company does not pay in full within 60 days from the date of submission for any service, we will require you to pay the balance due.

Miscellaneous Financial Information:

Returned checks will result in a Non-Sufficient Fund NSF fee of \$35.00 charged to your account. Services cannot resume until the returned check balance and the NSF fee have been paid in full. Balances that are not current (> 30 days past due) will result in a loss of comprehensive care appointment privileges. Emergency services will be available on a fee for service basis. Balances that are delinquent > 90 days will result in the account being transferred to a third-party collection agency and may incur additional fees and/or finance charges.



General Policies and Initial Consent

1. The ECU School of Dental Medicine accepts applications for care from all people regardless of age, sex, sexual orientation, race, creed, color, national origin or disability.
2. The ECU School of Dental Medicine treats patients and trains future dentists, residents, and dental specialists. Students provide patient care under strict faculty supervision. If your dental needs are too complex for student providers you may be referred to our graduate resident clinics or other treatment facilities including the Dental School's Faculty Practice or private practice.
3. Patients may have a translator present to interpret on their behalf during treatment if necessary.
4. Emergency dental care is provided for the treatment of dental emergencies only (pain swelling acute infection, bleeding etc.) and is limited to only such care as is necessary to treat the emergency. After hours emergency coverage will be available for patients of record only.
5. Your dental needs, recommended treatment and treatment options including risks associated with no treatment will be discussed before any treatment begins and you are encouraged to ask questions and participate in treatment planning decisions. Fees for recommended services will be explained when your comprehensive treatment plan is presented and if any additional treatment needs arise.
6. Dental treatment may include the need for additional radiographs, the use of local anesthesia, use of sedation if requested, prescription medications from time to time, and various dental materials.
7. The Dental School cannot assure you that one student/resident dentist will complete all of your treatment within a school year. Another student/resident may need to complete your treatment in a subsequent year.
8. The School of Dental Medicine is an academic institution and as such other students, residents, and faculty may observe your treatment. Your records, photographs, radiographs, and other clinical information may be used for educational and research purposes. Information from educational and research studies may be published. Your patient identifying information will be removed prior to such uses to insure your privacy.
9. All Dental School patient records are the property of the Dental School. Upon your written request the Dental School will release copies of the information in your records. There is a charge for records duplication and any associated delivery costs.
10. While we expect excellent treatment outcomes, no guarantees are offered, express or implied concerning the results of your care.
11. Your treatment may be discontinued if you fail two appointments without adequate notice, you repeatedly cancel appointments, you repeatedly are late for appointments, or you are uncooperative with students, faculty, or staff.
12. You are free to withdraw consent for treatment or use of your information for research at any time. Your agreement to allow use of your information for education and research studies is voluntary and you may choose not to take part now or at any time without penalty of loss of benefits to treatment. You will be asked if you do not wish to have your information used for such research.
13. You will be required to sign additional treatment or procedure or research specific consents when and if the need arises. These consents will highlight detailed information about those procedures, the benefits and associated risks.

By accepting your appointments, you acknowledge that you have read, understand, and accept the terms and policies discussed above and consent to a screening, comprehensive, and or emergency examination including recommended radiographs to establish a treatment plan at the ECU School of Dental Medicine.

Your signature is an acknowledgement that you are the biological parent/legal guardian and can provide consent on behalf of either a minor child or an adult unable to consent for him/herself. (Documents for legal guardianship are required.) If necessary, this form has been read to me.



Patient's Rights and Responsibilities

When you become a registered patient of the School of Dental Medicine, you have the following Rights and Responsibilities. Our administration, students, residents, faculty, and staff know and are committed to the following:

Patient Rights:

As a patient, you are entitled to the following:

- Considerate, respectful and confidential dental treatment.
- Emergency, incremental and comprehensive patient care.
- Dental treatment that addresses your primary complaint.
- To be fully involved in your dental care from treatment planning through completion of treatment.
- Treatment that meets the expectation of high-quality dental care.
- Continuity and completion of care.
- Dental care that will usually be provided by the same dental provider or dental team.
- Informed consent: You are entitled to advanced knowledge and an explanation of recommended treatment including what materials we will use, alternate treatment, and the risk of no treatment.
- The option to refuse treatment.
- The estimated cost of treatment ahead of time.
- A reasonable estimate of how long it will take for each dental visit and to complete your entire dental treatment plan.
- Referral if we are unable to provide for your dental needs.
- Access to the Patient Care Coordinators if you want to compliment or express concern about your dental treatment, our clinic, your student provider, our faculty or staff.

Patient Responsibilities:

As a patient you have the following responsibilities:

- To recognize that the ECU School of Dental Medicine is an educational institution and that dental treatment will proceed at a slower pace than available in private practice.
- Understand that we will strive to do our best at all times, but sometimes some dental treatments are not successful, and no guarantees are promised.
- To provide a reliable address, telephone number and/or email address where your assigned student, Patient Representative, or Patient Care Coordinator, may contact you and to keep them informed of any changes as treatment progresses.
- To provide complete and accurate information about your medical and dental history and to inform your student dentist, resident or faculty of any changes in your health as treatment progresses.
- To participate in discussions about your plan of care, ask questions, and to inform the student dentist, resident, or faculty if you do not understand proposed treatment.
- To tell us if you accept or refuse your proposed dental care.
- To pay for all services at the time treatment is rendered unless other arrangements have been made in advance through the proper channels.
- Patients with dental insurance must provide your current dental insurance card or verification of insurance eligibility at each appointment and pay your deductibles and estimated co-payment at the time of service.
- To be available at least twice each month for a three- or four-hour appointment to receive your dental treatment.
- To have a parent/legal guardian present if the patient is under 18 years of age.
- To make necessary arrangements for childcare as the school does not provide this service. Children are not allowed into the treatment areas except for their own appointments and may not be left unattended in the waiting room areas.



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Patient Registration Policy Documents

- To be prompt for your scheduled appointments, stay for the entire time scheduled, and to provide at least 24 hours' notice if you must cancel an appointment.
- To follow recommended instructions given about oral hygiene and other aspects of your care by your student dentist, resident or faculty and tell us if you do not understand or cannot follow our instructions.
- Control your service dog at all times in the clinic and the surrounding areas.
- To have you and the people with you show consideration and respect for other patients, staff, students, residents, faculty, and property in our clinics and surrounding areas of the building.

You may be dismissed from the ECU School of Dental Medicine clinic(s) if you cannot adhere to the above responsibilities.



**NOTICE OF PRIVACY PRACTICES
EAST CAROLINA UNIVERSITY HEALTH CARE COMPONENTS
ECU PHYSICIANS**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ THIS NOTICE CAREFULLY.**

EFFECTIVE: April 14, 2003

REVISED: October 13, 2014

At ECU Physicians (ECUP) and the other Health Care Components at East Carolina University (collectively referred to as ECU), we are committed to keeping your health information private. We are also required by law to keep your health information confidential.

This Notice describes the privacy practices of ECU. This Notice applies to all of your protected health information (PHI) that we keep here at East Carolina University. We are required to follow the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice.

Any change to this Notice may apply to PHI we already have about you and any PHI we may receive in the future.

Copies of our Notice are on hand at all of our Health Care Components. You can also contact the Privacy Officer whose address and phone number are at the end of this Notice. You can see the Notice at any of our sites and on our website at

<http://www.ecu.edu/ecuphysicians>.

**1. WE MAY USE AND DISCLOSE PHI ABOUT YOU WITHOUT YOUR AUTHORIZATION
IN THE FOLLOWING SETTINGS.**

- **Treatment:** We may use and disclose PHI about you to provide you with health care treatment.

EXAMPLE - Your doctor may share PHI about you with another health care provider, or by ordering lab or radiology services, or by calling in a prescription.

Electronic Health Information Exchange Program. ECUP, and any Health Care Component that utilizes the ECUP electronic health record system, uses an electronic health information exchange program that allows patient information to be shared with providers that are involved in the patient’s care. This exchange program provides a fast, secure, and reliable way to provide health information to providers. The health information is shared in accordance with this Notice of Privacy Practices and federal and state law. Patients have the right to opt out of the electronic health information exchange program; however, providers may still request and receive information using other methods, such as fax or mail.

If you have previously opted out of the electronic health information exchange program and would like to change this designation, you may obtain a form from patient registration staff or the ECU Physicians website. Complete the form and return to the address listed on the form or to the registration staff.



- **Payment:** We may use and disclose PHI about you to obtain payment for services. This could include certain sharing of PHI that your health insurance plan may require before it approves or pays for the health care services we advise for you.

EXAMPLE -Your health plan may have to approve any treatment. We will have to share your PHI with them so they will approve the treatment. We may also have to share more of your PHI with them after treatment so they will pay us.

- **Healthcare Operations:** We may use or reveal PHI about you to carry out certain business actions separately or as part of our involvement in an Organized Health Care Arrangement (OHCA) with Vidant Medical Center (VMC). These actions include, but are not limited to, quality assessment activities, training of medical students and residents, licensing, solving complaints, and carrying out other business actions.

EXAMPLE - We are reviewed by outside groups that measure the quality of the care our patients receive. They include government agencies or accrediting groups. We also review and measure the skills and training of the doctors that care for you. Both ECU and non-ECU health care workers not directly involved in your care may do such reviews.

Shared Electronic Medical Record System with Vidant Health. ECUP, and any Health Care Component that utilizes the ECUP electronic health record system, shares its electronic medical record system with Vidant Health (VH). This means that if you have ever been hospitalized at VMC or any other Vidant hospital, ECUP staff and physicians will be able to access your PHI on your medical record at Vidant if this access is required for your treatment at ECUP. Also, if you ever receive treatment at any Vidant hospital, any approved staff member or physician working at VMC or any other Vidant hospital may be able to access your PHI in our medical record if such access is required for your treatment while you are in the hospital. Access of your PHI by individuals at ECUP or VMC may also be permitted if it is required for payment for treatment or the mutual health care operations of ECUP and VH. The ability of your health care team to access your PHI at both ECUP and VH will help us provide you with better quality care.

2. WE MAY USE AND REVEAL PHI ABOUT YOU IN A NUMBER OF OTHER SETTINGS IN WHICH YOU DO NOT HAVE THE CHANCE TO AGREE OR OBJECT. THESE MAY INCLUDE:

- **Required By Law:** For certain judicial or other administrative actions. For example, we may reveal PHI about you in response to a court order.
- **Public Health:** For public health activities required by law to receive the information.
- **Health Oversight:** To health oversight agencies for legally allowed audits, investigations, certain government programs, and inspections.
- **Abuse, Neglect, or Domestic Violence:** To a public health expert for reports of child abuse or neglect. We may reveal PHI if we believe that you have been a victim of abuse, neglect or domestic violence to governmental agencies who are allowed to receive such information.



- **Food and Drug Administration:** To a person required by the Food and Drug Administration to report harmful events, product defects or problems, tracking of products to permit recalls, or to conduct post marketing surveillance
- **Law Enforcement:** We may disclose your PHI to law enforcement for several law enforcement reasons including (1) legal courses of action required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the site of the practice, and (6) medical emergency when it is likely that a crime has occurred.
- **Serious Threat to Health or Safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Coroners, Funeral Directors, and Organ Donation:** To a coroner or medical examiner for identification purposes, or to find out the cause of death. We may also reveal protected health information to a funeral director in order to permit them to carry out their duties. PHI may be used and revealed if you are an organ, eye, or tissue donor.
- **Research:** PHI may be used for research without the individual's authorization if the University and Medical Center Institutional Review Board (UMCIRB) grants a waiver of the requirement for authorization. Two situations that require neither authorization nor waiver of authorization: 1) reviews preparatory to research, and 2) research on decedent's information
- **Criminal Activity:** We may use or disclose PHI as necessary to prevent or lessen a serious threat to the health or safety of a person.
- **Specialized Government Functions:** We may use or disclose PHI for the purpose of eligibility determination by the Department of Veterans Affairs. We may also reveal your PHI with federal officials for conducting national security activities and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- **Inmates and other Law Enforcement Custodial Situations:** If you are a prisoner and your doctor created or received your PHI in the course of giving care to you, we may use or disclose PHI as necessary to a correctional institution or law enforcement official.
- **Worker's Compensation:** We may use or disclose PHI as necessary to support worker's compensation claims pending before the Industrial Commission.

3. OTHER USES AND DISCLOSURES OF PHI ABOUT YOU.

- **Appointment Reminders:** We may contact you to remind you of an appointment for treatment.
- **Prescription Refill Reminders:** We may contact you to remind you of a prescription refill.
- **Information About Treatment, Services or Products:** We may use or reveal PHI to manage your care. This may include telling you about treatments, services, or products on hand.



- **Fundraising Activities:** We may use or reveal PHI about you in order to contact you to raise money for ECU and its Health Care Components. If you do not want us to contact you about fundraising activities, you must tell our Privacy Officer as described below.
- **Family or Personal Representative:** In certain situations, we may use or reveal PHI to a family member, other relative, or a close personal friend of the patient, or any other person identified by the patient, PHI directly relevant to such person's involvement with the patient's care or payment related to the patient's care.

4. ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION.

- **Written Authorization:** For any reason other than those listed above, we will ask for your written authorization before we use or disclose your PHI. Specifically, the following reasons require your prior written authorization for most uses and disclosures of: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes; and (iii) disclosures of PHI that constitute a sale.
- **Ability to Revoke a Written Authorization:** Any written authorization we receive can be canceled at any time in writing. We will not disclose PHI about you if you cancel your authorization unless we did this prior to your cancellation

5. YOUR RIGHTS REGARDING PHI ABOUT YOU.

- **Request Limits:** You may request further limits on our uses and disclosure of PHI about you. We are not required to agree to all requested limits. If we agree, there still may be circumstances such as those described above in which you cannot object. Ask the clinic front desk or contact the Privacy Official as described below if you want to request further limits on your PHI.
- **Request for Required Restrictions:** ECU is required to grant your request for restriction on the disclosure of PHI when such disclosure is (i) to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and (ii) such PHI pertains solely to a health care item or service for which you, or someone on your behalf other than your health plan, has paid ECU in full for the item or service.
- **Different ways to Contact You:** You may request different ways for us to contact you about your PHI. Examples include using a different address, phone number, or mailing address. We will honor your request if we can. Ask the clinic front desk or contact the Privacy Officer as described below if you want to change the way we contact you about your PHI.
- **Right to see and get Copies of PHI:** In most cases, you may see and receive a copy of your PHI kept in our clinical or billing records used to make decisions about you. You have a right to obtain copies of your PHI in electronic format and direct ECU to transmit the requested PHI to a clearly, conspicuously and specifically identified entity or person. We may charge you for copies or for providing you your PHI in electronic format. There are times in which we do not have to fulfill your request. We will write to you in these cases. Ask the clinic front desk or contact the Privacy Officer as described below if you want to see or get copies of your PHI.
- **Right to Request Amendments of PHI:** You may request that the PHI in your medical record be amended (changed). We may turn down your request if we did not create the information, or



if we believe the information is correct. If we turn down a request, we will write to you and will describe your rights for further review. Ask the clinic front desk or contact the Privacy Officer as described below if you want to request an amendment.

- **Listing of Disclosures we have made:** You may request a list of the persons or places that PHI about you was revealed to for up to the last six (6) years. This does not include PHI disclosed because of your need for treatment, payment, our health care operations, and those allowed by law. Ask the clinic front desk or contact the Privacy Officer as described below if you want to request a listing of disclosures.
- **Copy of this Notice:** You may request a copy of this Notice at any time. This will be on hand in our patient care delivery sites, or you may contact the Privacy Officer as described below.

6. NOTICE OF BREACH OF UNSECURED PHI

- **Breach Notification:** We are required by law to notify you if a breach of your unsecured PHI occurs.

7. YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES.

- If you think we have denied your privacy rights described in this Notice, if you have any questions about this Notice, or you want to complain to us about our privacy practices, you can contact the person below:

**HIPAA Privacy Officer
East Carolina University
Physicians Quadrangle N
Greenville, NC 27834**

Phone 252-744-5200 or Email HealthCarePrivacy@ecu.edu

You may also send a written complaint to the Secretary, Department of Health and Human Services.

IF YOU FILE A COMPLAINT, WE WILL NOT TAKE ANY ACTION AGAINST YOU OR CHANGE OUR TREATMENT OF YOU IN ANY WAY.



CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

Formulary and benefit transactions --- Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions --- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status notification --- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that ECU SoDM can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to ECU SoDM to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Electronic Patient Confirmation Consent:

Text Message * - _____
Mobile Phone Number *

Email - _____
Email Address

Phone Call - _____
Phone Number *

* Normal text and phone message rates apply.

You can opt-out of 1 or more of these options at any time by calling the clinic and requesting to opt-out.
Participation is not required

Patient Name

Medical Record Number

Date



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Use of Patient Information:

Do you consent to educational use of your research information for research purpose?

Do you consent to educational use of any images taken for clinical purposes?



I have read, I understand and I agree with the terms of the Patient Appointment Agreement.

I have read, understand and I agree with the terms of the Financial Policy Agreement.

I have read, I understand and I agree with the terms of the General Policies and Initial Consent Form.

I have read, I understand and I agree with the terms of the Patient’s Rights and Responsibilities Agreement.

I hereby provide informed consent to enroll me in the ePrescribe Program

By signing below you acknowledge that you have read, understand, and accept the terms and policies checked above and consent to a screening, comprehensive, and or emergency examination including recommended radiographs to establish a treatment plan at the ECU School of Dental Medicine. Your signature is an acknowledgement that you are the biological parent/legal guardian and can provide consent on behalf of either a minor child or an adult unable to consent for him/herself. (Documents for legal guardianship are required.) If necessary, each form and policy has been read to me.

Print Patient Name

Medical Record Number

Date

We are legally required to give you our **Notice to Patients about Our Privacy Practices (REVISED: September 23, 2013)** and to get a signed statement that you received it. By signing below, you are only confirming that you have received our **Notice to Patients about Our Privacy Practices (REVISED: September 23, 2013)**.

Print Patient Name

Date

Patient or Guardian Signature