Dear Parent or Guardian,

Welcome to our office and thank you for choosing us as your child's dentist. We will continually strive to provide your child with the finest care available.

To help accomplish this, we would like you to read the following:

- Please have your child use the restroom after checking in for the appointment.
- Please arrive 15 minutes prior to the appointment time. This allows relaxation and playtime for your child. If you are more than ½ your appointment time late, you will be rescheduled.
- Due to OSHA regulations food and drink are prohibited in our treatment area.
- We have two offices to serve you.

  Our Amberglen office is located on Amberbrook Drive just off Cornell Road between 206th Ave. and Macy's. Other landmarks include: Bugatti's and Insomnia Coffee.

  Our Murrayhill office is located in the Murray Scholls Town Center, at the corner of Scholls Ferry and Murray Blvd. We are behind the stores and restaurants, across the parking lot from 24 Hour Fitness. Other Landmarks include: Starbucks, Walgreens, and Kaiser.
- An appointment card, new patient form, and appointment and financial policy, and map are enclosed. Please complete **both** sides of the new patient form, sign and date the financial policy and any other forms included in this packet. Return these to our office at the first appointment.
- Due to new Federal Trade Commission regulations regarding Identity Theft Red Flags Rule, you will be required to show photo identification with your submitted paperwork, Please keep in mind that the parent or legal guardian must be also present at the appointment in order for your child to be seen.

We are looking forward to meeting you and your child! Please give us a call if you have any questions at Amberglen, 503.641.8800 or at Murrayhill, 503.579.0304.

Sincerely,

Dr.'s Carolyn, Ashley, and Downey

This page intentionally left blank

About your child:

Child's full name: _____ Sex:

Nickname: _____ Birthdate: _____ Age: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Parent Information: ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Guardian

Full Name: _____ Birthdate: _____

Home Address (If different than child):_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Social Security #: _____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widow Do you have dental insurance? ☐No ☐Yes

Employers Name (Company): _____

Insurance Company: _____ Insurance Phone #: _____

Claims mailing address: _____

City: _____ State: _____ Zip: _____

ID# (If different than SS#): _____ Group #: _____

Parent Information: ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Guardian

Full Name: _____ Birthdate: _____

Home Address (If different than child):_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Social Security #: _____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widow Do you have dental insurance? ☐No ☐Yes

Employers Name (Company): _____

Insurance Company: _____ Insurance Phone #: _____

Claims mailing address: _____

City: _____ State: _____ Zip: _____

ID# (If different than SS#): _____ Group #: _____

Responsible Party Information: : ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Guardian

(This person is responsible for the account.) If different than above, please continue.

Full Name: _____ Birthdate: _____

Relationship to patient: _____ Social Security #: _____

Home Address (If different than child):_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Who is responsible for making dental appointments?

Name _____ Home Phone _____ Work Phone _____

Would you like an email reminder about appointments? ☐Yes ☐No
Email:_____

Would you like a text message reminder about appointments? ☐Yes ☐No
Cell Phone:

_____

How did you hear about our office? _____

CONSENT FOR TREATMENT

I hereby authorize Behind the Smile Dentistry for Children or the designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my child's dental needs. Upon such diagnosis, I hereby authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree that parents are responsible for fees and services rendered for treatment of a child. **I understand that my estimated portion is due in full at each appointment.**

Parent/Guardian's Signature: _____ Date: _____

BEHIND THE SMILE
DENTISTRY FOR CHILDREN
APPOINTMENT AND FINANCIAL POLICY

WHEN WE WELCOME A NEW FAMILY TO OUR PRACTICE, WE ALSO WELCOME ANY COMMENTS OR QUESTIONS YOU MAY HAVE ABOUT OUR POLICIES. PLEASE READ THE FOLLOWING, SIGN AND RETURN ON THE FIRST VISIT.

An appointment written in our schedule, with your child's name on it, is a bond of trust that we will be here to serve you and that you will be present and on time for that appointment. For all of us, time is important and we do our best to ensure that you are seen promptly. Working with small children, as we do, there are no guarantees. We appreciate your patience. Please be assured that your child will also receive the same extra attention. _____ (initial)

As a courtesy to our patients, we will attempt to confirm your scheduled appointment. Feel free to leave a message on our 24 hour voicemail if you have any questions or concerns. However, once you have made an appointment, remembering and keeping it is your responsibility. Confirmation is simply a courtesy to you. _____ (initial)

We make every effort to be on time, we hope you will also. If you must change an appointment, we request 48 hours advance notice. In the event of illness, call the office as soon as possible. Feel free to leave a message on our 24 hour voice mail. We have many children waiting for earlier appointments. We reserve the right to charge a fee for broken appointments. _____ (initial)

Our office provides dental care as determined by the American Dental Association and the American Academy of Pediatric Dentists. Insurance companies may have limits or exclusions for the recommended treatment. It is up to you to know your insurance policy and any possible limitations and exclusions.
_____ (initial)

Payment is requested at the time treatment is provided. We accept most insurance plans and will bill your primary and/or secondary for you. If you have dental insurance we collect the estimated amount not covered at each appointment. You need to provide us complete insurance information and answer any insurance inquiries. In the event of insurance delays or disputed claims beyond 45 days, you will need to pay your account in full and arrange for reimbursement by your carrier. Please remember that insurance companies only assist in payment and rarely cover your full costs. If your dental plan does not pay the amount we have estimated, the balance is your responsibility.
_____ (initial)

Finance charges are not assessed on **current** accounts. For accounts 45 days past due, a finance charge will be imposed on services not paid in full. The finance charge is a monthly rate of 1.50%, which is equal to a yearly rate of 18%, with a minimum charge of $1.00. A billing fee is imposed after 45 days at the fee of $5.00 per month. _____ (initial)

A claim will be submitted to my insurance carrier, if applicable, and authorize release of any necessary information to them. I understand that Dr.'s Carolyn, Ashley and Downey are not participating/ preferred providers with my insurance plan and that I am responsible for any balance not covered by such plans. I authorize my insurance company to send payment directly to Murrayhill Pediatric Dentistry P.C. I agree to pay all costs of collections, including, but not limited to, reasonable attorney fees. . _____ (initial)

Method of Payment: _____ Cash _____ Check _____ Care Credit _____ Debit/Bank Card _____ HSA

A $38.00 fee is charged to your account for any bank returned check (NSF). An $85 processing fee will be assessed if your account is deemed delinquent and you will be dismissed from our practice. We will refund any credit back to you as soon as we can. All refunds will be made to the account holder and address we have on file. . _____ (initial)

I acknowledge I have read this financial policy and I am responsible for all charges whether or not paid by insurance. If I have insurance, I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Eric A. Downey, DDS, Carolyn Muckerheide, DDS or Ashley Schaaf, DDS, MPH. 3.10.14

Signature _____ **Date** _____

Print Name _____

MurrayHill Pediatric Dentistry P.C.
DBA: Behind The Smile Dentistry for Children

Sample 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _10__/_01___/_2015___, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information of to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writie at any time. You revocation will not effect any use or disclosures permitted by you authorizatioin 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.

HOW WE MAY SEND HEALTH INFORMATION ABOUT YOU

Your protected health information(PHI) includes information relating to your mental or physical health and to the health care provded to you including materials like your dental records, dental X-rays, and payment records. Some documents containing PHI may include such sensitive personal information as a social security number, credit card number, mental health diagnosis, genetic information, alcohol/ substance abuse records, positive HIV status, and other kinds sensitive information.

Sometimes our dental practice needs to send PHI to the patient or someone else, such as a specialist. There are various ways to send PHI including email or other electronic means. Our office does not encrypt all email or other electronic forms of communication.

There is a risk that unencrypted information may be acquired by hackers or recived by unintended recipients. If you are concerned about the security of the PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your or youc childs health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be

entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your or you childs health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your or your childs health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your or your childs health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your or your childs health information to your family or friends or any other individual identified by you when they are involved in your or your childs care or in the payment for your care. Additionally, we may disclose information about you or your child to a patient representative. If a person has the authority by law to make health care decisions for you or your child, we will treat that patient representative the same way we would treat you with respect to your health information.

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

Required by Law. We may use or disclose your or your childs health information when we are required to do so by law.

Public Health Activities. We may disclose your or your childs health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your or your childs PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your or your childs PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your or your childs PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your or your childs PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your or your childs health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.
If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

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

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official:Heidi Salman

Telephone: (503) 641- 8800 Fax:(503) 352-0721

Address: 2380 NW Amberbrook Dr. Hillsboro, Or. 97006

E-mail: Heidi@behindthesmile.com

Behind the Smile- Dentistry for Children

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

Signature:_____

Date:_____

Please list all children:

_____

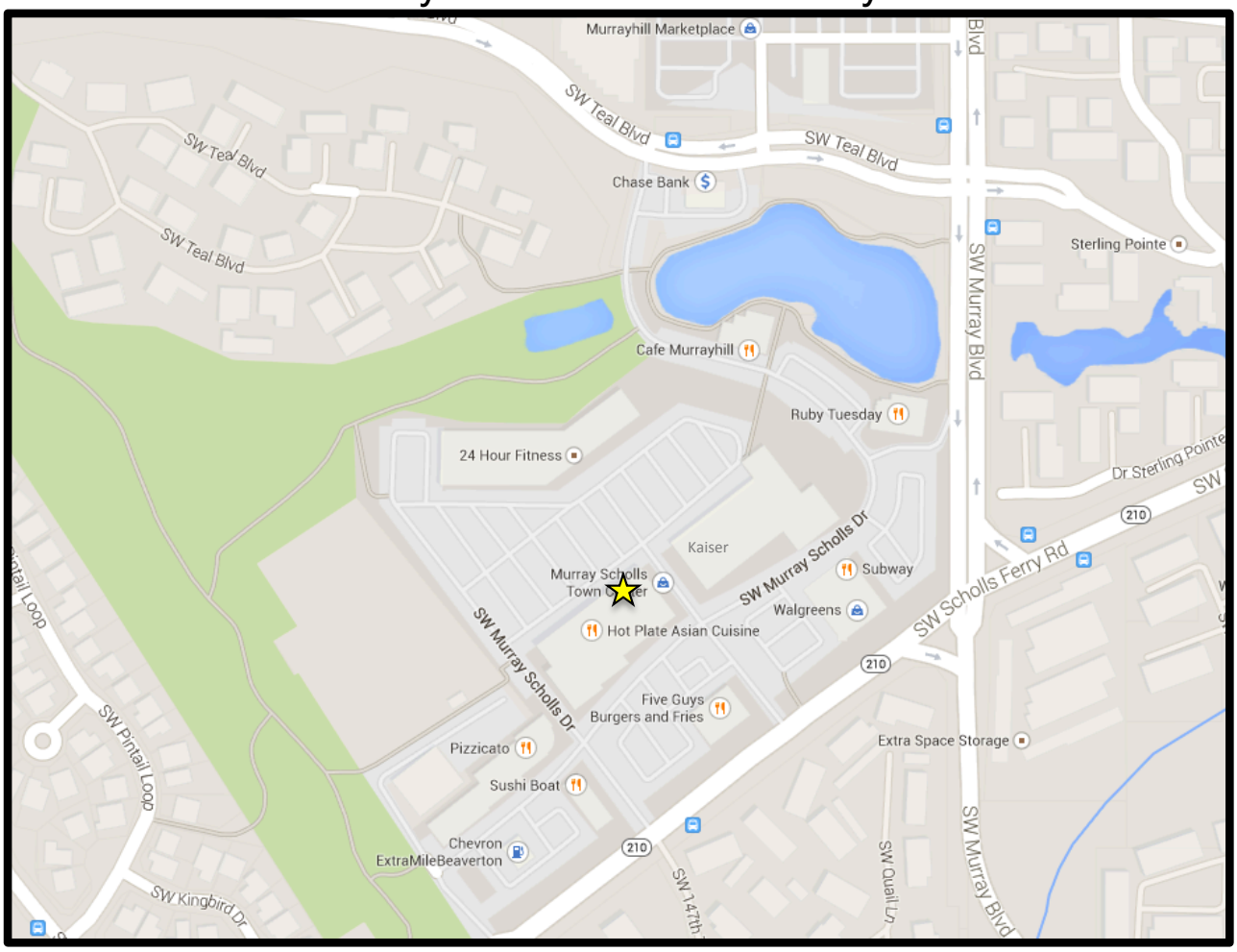
_____

_____

_____

_____

Dentistry for Children at Murrayhill



Dentistry for Children at Amberglen