Orthodontics

Ralph S. Kurti, D.D.S., MS., P.A.

Member
American Association of
Orthodontists

WELCOME TO OUR OFFICE

We are pleased to welcome you as a new patient to our office . We hope that this information will enable you to become more familiar with our services and answer some questions that you may have.

OFFICE HOURS

Our patient treatment hours are Monday's & Wednesday's in our Franklin office 7:30 am to 5 pm, Tuesday's & Thursday's in our Murphy office 8 am to 5 pm and one Friday a month 8 am to 4 pm. In our Robbinsville office we are there one Friday a month 8 am to 4 pm.

APPOINTMENTS

Patients are seen by appointment only. It is impossible for us to see all of our patients after school, therefore we will do our best to rotate appointments to keep the number of times you have to check out of school to a minimum.

To avoid delays, please call at least 24 hours in advance of your appointment if you have loose or broken brackets. If you are unable to keep an appointment and need to reschedule, please let us know as soon a possible. Rescheduling my result in a less desirable appointment time. Time is set aside each day to see emergency patients.

FINANCIAL ARRANGEMENTS

We want your investment in a lifetime of beautiful smiles to work for you from the very first appointment. A payment plan may be set up on a monthly basis for your convenience. We will sit down with you and develop a customized payment plan that will work comfortable for you.

INSURANCE

If you have orthodontic insurance, we will be happy to do the necessary paperwork in some cases accept assignment to assure that you maximize your full benefit.

PATIENT COOPERATION

Successful treatment is based on patient cooperation with appliances, elastic wear, and good oral hygiene. Broken appliances and missed appointments add time to treatment and interrupt progress. Please see your dentists for regular exams and cleanings. Working together will give us "Something to Smile About."

We welcome your questions at any time and look forward to working with you.

Franklin Office
Physical Address: 250 White Oak St.
Franklin, NC 28734
Mailing Address: PO Box 658
Franklin, NC 28744
Phone (828) 524-7477
Fax (828) 524-848

Murphy Office
Physical Address: 426 Hiwassee St.
Murphy, NC 28906
Mailing Address: PO Box 603
Murphy, NC 28906
Phone (828) 837-5004
Fax (828) 835-3464

Robbinsville Office
Physical Address: 41 Ghormley St.
Robbinsville, NC 28771
Mailing Address: PO Box 603
Murphy, NC 28906
Phone (828) 479-3937

Ralph S. Kurti, D.D.S., M.S., P.A.

NOTICE OF PRIVACY PRACTICES
Effective: April 1, 2003

This notice describes how dental information about you may be used and disclosed in this office and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPAA provided penalties for covered entities that misuse personal health information. As required by HIPPAA, 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include braces, orthodontic appliances, extractions, teeth whiting services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your orthodontic services
- **Health Care Operations** include the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our charting protocols, etc.

In addition, your confidential information may be used to remind you, a family member or your designated representative of an appointment (by phone, email, fax, or mail) or provide you with information about treatment options or other health-related services including release of information to representatives and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected health information when we are required to do so by federal, state, or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law including but not limited to: a) response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, b) response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the

request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by law enforcement officials for any circumstances required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member U.S. or foreign military forces (including veteran) and if required by appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials, or foreign heads of state or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: a) for the institution to provide health care services to you, b) for the safety and security of the institution, and/or c) to protect your health and safety or the health and safety of other individuals or the public. We may release PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

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 action relying on your authorization.

You have certain right in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- 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 request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request and amendment to your PROTECTED HEATH INFORMATION.
- The right to receive and accounting of disclosures of PROTECTED HEATH INFORMATION outside of treatment, payment, and health care operations.
- The right to obtain a paper copy of this notices from us upon request.

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 INFORMATION.

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 notices provisions effective for all PROTECTED HEALTH INFORMATION the we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complain with us at the address below, or with the Department of Heath & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact the off of:

RALPH S. KURTI, D.D.S., MS., P.A.

P.O. Box 658
Franklin, NC 28744-0658
(828) 524-7477

Or

P.O. Box 603
Murphy, NC 28906-0603
(828) 837-5004

For more information about HIPPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

(844) 696-6775 (toll free)

Privacy Practices

Ralph S Kurti DDS MA PA
PO Box 603
Murphy, NC 28906

Office (828) 837-5004
Fax (828) 835-3464

(A) Patient

Name:_____

Address: _____

_____

Chart Number: _____ Telephone: _____ Date of Birth: _____

(B) Acknowledge of Receipt

Signed (Patient or Guardian) _____

Printed Name _____

Relationship to Patient _____ Date _____

(C) Good Faith Effort to Obtain Acknowledgement

Describe effort to obtain_____

_____

_____

Reason (if known) why individual whould not sign _____

_____

I _____ Verify that the above information is correct.

Signed (person attempting to obtain acknowledgment)_____

Print Name _____ Title _____ Date _____

Ralph S. Kurti, D.D.S., MS., P.A.

426 Hiwassee St.
P.O. Box 603
Murphy, NC 28906-0603
(828) 837-5004

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Patient Info

Patient's Name _____ Preferred Name _____ Age _____ Sex _____

Address _____, City _____, State _____, Zip _____ Email Address _____

Home Phone _____ Cell Phone _____ Birthday _____ Social Security# _____

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

Who noticed the orthodontic problem? Patient ☐ Parent ☐ Dentist ☐

Patient's Dentist _____ Physician _____

Last Dental Visit _____ Has dentist removed any teeth? _____

If Patient is a minor please complete this section.

Parent's or guardian's name _____ Is patient adopted? Yes ☐ No ☐

Responsible Party Information

Your Relationship to Patient _____ Insured? Yes ☐ No ☐ Social Security# _____

Name _____ Birthday _____ Marital Status _____

Address _____, City _____, State _____, Zip _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

How long at this address _____ Previous Address (if less than 3 years) _____, City _____, State _____, Zip _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Relationship to Patient _____ Insured? Yes ☐ No ☐ Birthday _____

Name _____ Social Security# _____

Employer _____ Occupation _____ No. Years Employed _____

Work Phone _____ Cell Phone _____

Complete the following section if there are any other persons who could be considered part of the responsible party.

Relationship to Patient _____ Insured? Yes ☐ No ☐ Social Security# _____

Name _____ Birthday _____ Marital Status _____

Address _____, City _____, State _____, Zip _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

How long at this address _____ Previous Address (if less than 3 years) _____, City _____, State _____, Zip _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Relationship to Patient _____ Insured? Yes ☐ No ☐ Birthday _____

Name _____ Social Security# _____

Employer _____ Occupation _____ No. Years Employed _____

Work Phone _____ Cell Phone _____

Emergency Information

Name of nearest relative not living with you _____ Phone _____

Complete address _____

If you have insurance, please give your insurance card to the receptionist at the front desk, so they can make a copy of it.

I understand that credit bureau reports must be obtained and that with out this permission no treatment will be started.

Signature (Parent's signature if minor) _____ Date _____

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Date_____

Patient's Name_____

Date of Birth_____

Questionnaire

Describe orthodontic problem in you own words. _____

_____

What is your main concern regarding this orthodontic problem? Cosmetic ☐ Functional ☐

Describe patients temperament. _____

What is patients hobbies and sports? _____

List in order of importance three things you would like to get out of your orthodontic treatment.

1. _____ 2. _____ 3. _____

TMJ Questions	Yes	No
Do you ever have ringing in your ears?	☐	☐
Do you ever have dizziness?	☐	☐
Do you have earaches?	☐	☐
Do you have headaches?	☐	☐
Do you have Neck, shoulder or back soreness?	☐	☐
Does your jaw ever lock open or closed?	☐	☐
Does your jaw joint ever hurt?	☐	☐

Airway Questions

History of mouth breathing?	☐	☐
Have tonsils and adenoids been removed? When_____	☐	☐
History of ear infections?	☐	☐
History of frequent colds?	☐	☐
History of asthma?	☐	☐
History of allergies?	☐	☐
History of sinus infections? Frequency_____	☐	☐
History of snoring at night?	☐	☐
History of sleep apnea?	☐	☐
Any speech abnormalities?	☐	☐

General Health Questions	Yes	No
(Underline pertinent condition or explain in comments.)		
Does the patient have a health problem now?	☐	☐
History of injury to face, head or teeth?	☐	☐
History of liver or kidney problem, epilepsy, endocrine disorders?	☐	☐
History of heart trouble, rheumatic fever, diabetes, bleeding disorders?	☐	☐
Have had AIDS or Hepatitis B?	☐	☐
Is patient under a doctors care or taking medication?	☐	☐
History of trauma or accidents?	☐	☐
Has patient reached puberty (girls-menstruation, boys voice change)?	☐	☐
Is patient allergic to any medication, latex, or metals? What _____	☐	☐

Does Patient Have Any Of The Following Habits

Finger or thumb sucking?	☐	☐
Teeth grinding?	☐	☐
Clinching?	☐	☐
Nail biting?	☐	☐

Are You Aware That The Success Of Treatment Is Dependent On Patient Cooperation?	☐	☐
Has Patient had previous orthodontic examination?	☐	☐
Do you anticipate a transfer or move in the near future?	☐	☐
Has anyone in the family had orthodontic care?	☐	☐

Comments_____

_____

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426 Hiwassee St.
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Dental Insurance Claim Consent

Chart _____

Policy Holder/Subscriber Information(For Insurance Company)

1. Full Name _____ Date of Birth _____ Gender M ☐ F ☐

Address _____ City _____ State _____ Zip _____

Policyholder/Subscriber(SSN or ID#) _____ Plan/Group Number _____

Employer Name _____

Please fill out the information in box# 2 if there is dual insurance coverage.

Policy Holder/Subscriber Information(For 2nd Insurance Company)

2. Full Name _____ Date of Birth _____ Gender M ☐ F ☐

Address _____ City _____ State _____ Zip _____

Policyholder/Subscriber(SSN or ID#) _____ Plan/Group Number _____

Employer Name _____

Patient Information

3. Relationship to Policyholder/Subscriber in Box#1 Self ☐ Spouse ☐ Dependent Child ☐ Other ☐

If Applicable, Relationship to Policyholder/Subscriber in Box #2 Self ☐ Spouse ☐ Dependent Child ☐ Other ☐

Full Name _____ Date of Birth _____ Gender M ☐ F ☐

Address _____ City _____ State _____ Zip _____

Student Status FTS ☐ PTS ☐

Authorizations

4. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected heath information to carry out payment activities in connection with this claim.

Patient/Guardian Signature _____ Date _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Ralph S. Kurti D.D.S., MS., P.A.

Subscriber Signature for Box#1 _____ Date _____

Subscriber Signature for Box#2 _____ Date _____