

Kari A. Cunningham, DMD, LLC - Panther Pediatric Dentistry
Patient Health Information

Patient Name: _____ Today's Date: _____
Last First MI
Birth Date: _____ Nickname: _____ Preferred Pronouns: _____
 Male Female Non-binary Transgender Male Transgender Female Other: _____

Health Information

Has the child ever had any of the following? Please check all those that apply:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> HIV Positive/AIDS | <input type="checkbox"/> Premature: _____ weeks |
| <input type="checkbox"/> Allergy - Food
_____ | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hormone Deficiency | <input type="checkbox"/> Previous Dental Surgery |
| <input type="checkbox"/> Allergy - Drug
_____ | <input type="checkbox"/> Congenital Heart Defect
_____ | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Respiratory Problems
_____ |
| <input type="checkbox"/> Allergy - Seasonal
_____ | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> RSV |
| <input type="checkbox"/> Allergy - Other
_____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Eczema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sickle Cell Anemia Trait |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Eye Condition | <input type="checkbox"/> Measles | <input type="checkbox"/> Stomach Problems
_____ |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> G6PD Deficiency | <input type="checkbox"/> Mental Disorders
_____ | <input type="checkbox"/> Surgeries
_____ |
| <input type="checkbox"/> Cancer
_____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> OCD (Obsessive Compulsive Disorder) | <input type="checkbox"/> Unknown medical history due to adoption/foster care |
| | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> ODD (Oppositional Defiant Disorder) | <input type="checkbox"/> Urinary Tract Problems |
| | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteogenesis Imperfecta | <input type="checkbox"/> Vitamin Deficiency |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pertussis/Whooping Cough | <input type="checkbox"/> Xerostomia (dry mouth) |
| | <input type="checkbox"/> High Blood Pressure | | |
| | <input type="checkbox"/> Herpes Simplex I or II | | |

Reason for this visit: _____ Last Dental Visit: _____

- Are your child's vaccines (immunizations) up to date?** Yes No If no, please explain: _____
- Name of Physician or Pediatrician: _____
- List any medications your child is taking: _____
- Is your child under the care of a specialist for a medical condition listed above? Yes No
If yes, please explain: _____
- Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Does your child have any health conditions that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my child's health to report, I will inform the doctors and staff at the next appointment without fail.

Signature of parent or guardian

Date:

Referral Information

- Whom may we thank for referring you to our practice? A patient or family/friend: _____ (name)
- School Google Dental Office Pediatrician Advertising Social Media Employer
- Insurance Listing Other/Name _____

Kari A. Cunningham, DMD, LLC – Panther Pediatric Dentistry Patient Policies

Patient Name: _____ Birthdate: _____
Last First MI

1. In an effort to keep our Panther Cubs, their families, and our Panther Pride safe, **FACE MASKS ARE REQUIRED** for all individuals over the age of 2 years. A mask can be purchased for a \$2.00 cash donation to a worthy cause.
2. The parent/legal guardian may not leave the office or hallway of Panther Pediatric Dentistry during a child's dental visit. If the parent/guardian leaves the office area or hallway during patient care, please understand that treatment may be stopped and the child may have to be rescheduled for treatment to be completed.
3. Panther Pediatric Dentistry requests that the parent/legal guardian remains in the lobby or hallway during the patient's dental visit. Exceptions may be made under certain circumstances and when it is in the best interest of the patient. Parental presence or absence is an accepted and recognized behavior guidance tool of the American Academy of Pediatric Dentistry. The team at Panther Pediatric Dentistry may use the tool to safely and effectively complete treatment.
4. The parent/legal guardian **MUST BE PRESENT** at the first dental visit (with photo identification and must provide proof of guardianship) to complete new patient paperwork and give consent for treatment. Foster parents must also provide the document that gives consent from the county to provide diagnostic and preventive services for the child. Without proper documentation or the required adult, the appointment may be canceled, resulting in a missed appointment.
5. **Missed Appointment Policy:** Panther Pediatric Dentistry requires a 24-business hours' notice for cancellation of any appointment. If a 24-business hours' notice is not given, it will be counted as a missed appointment and the following outcomes will apply, depending on the circumstance:
 - 5a. **New Patients** to the practice, if you call to cancel with less than 24-business hours' notice, the ability to schedule an appointment in advance will be lost and a child may be seen on a Same Day Only basis (see below).
 - 5b. **New Patients** to the practice who NO CALL and NO SHOW to the first appointment will be inactivated indefinitely and Panther Pediatric Dentistry will not enter into a doctor/patient/parent relationship with the family.
 - 5c. **Existing patients**, after two missed appointments (no-show or cancel with less than 24-business hours' notice), the ability to schedule an appointment in advance will be lost and a child may be seen on a Same Day Only basis.
6. **Late Patient Policy:** Panther Pediatric Dentistry will try to work a late patient into the schedule, if possible, and planned treatment may be modified based on time available. However, if a child arrives more than 10 minutes late for the appointment, please understand that the appointment may be canceled and counted as a missed appointment.
7. **Same Day Only Status:** A new patient may be placed in Same Day Only (SDO) status when an appointment is canceled with less than 24-business hours' notice. An existing patient may be placed in SDO status when two missed appointments have occurred (no-show or cancel with less than 24 business hours' notice). Being placed in SDO status limits your ability to make an appointment for your child in advance. You can call on the same day patient care is taking place and see if there is availability in the schedule for your child to be seen on the same day. If you are offered an appointment and you keep the appointment, you regain the ability to schedule future appointments. If a future appointment is missed, your child will return to SDO status and your family risks being dismissed from the practice.
8. **Inactive Patients:** We are committed to providing regular dental visits every 6 months to monitor a child's growth and development. If your child has not been seen by our providers in **12 months**, we will conclude that you have secured a dental home with another provider. Your child's chart will be inactivated and dismissed from the practice. Children who NO CALL and NO SHOW for their first appointment, graduate from the practice, are transferred to another dentist, or who have outstanding account balances greater than 90 days, will be inactivated and dismissed from the practice. Disrespect, being argumentative, using profane language, challenging our policies are also grounds for dismissal from the practice.
9. **Authorization of Consent, Release of Information for Treatment, Payment or Operations:** I authorize Kari A. Cunningham, DMD, LLC (dba: Panther Pediatric Dentistry) to perform an examination, cleaning, fluoride treatment, and take dental x-rays as needed to fully diagnose and provide a comprehensive treatment plan for my child. You may release any information about me or my child to my insurance or its agents to assist in determining my benefits and/or benefits payable for related services performed on my child.

Signature (Parent/Legal Guardian): _____ Date: _____

10. **HIPAA Acknowledgement:** I have had the opportunity to review a copy of this office's Notice of Privacy Practices and I consent to the use of my and my child's protected health information for treatment, payment, and the healthcare operations of Kari A. Cunningham, DMD, LLC as summarized in the notice of privacy practices.

****You may refuse to sign this privacy practices acknowledgement****

Signature: _____

I refuse to sign this privacy practices acknowledgement
(Check if you refuse to sign)

Date: _____

Staff Initials: _____ Date: _____



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 1/2/2020, 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your 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 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 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 health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities. At times dental students may shadow in our office as part of their training. We will ask you to complete a form giving permission if a student is present on your child's treatment day.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, 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 health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your 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 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 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 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 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 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.

Privacy Official: Dr. Kari A. Cunningham
Phone: 216-938-8501 **Fax:** 216-938-8502
Address: 26250 Euclid Avenue Suite 203
Euclid, OH 44132
Web: office@pantherpediatricdentistry.com
Website: www.pantherpediatricdentistry.com

