BIEN VENIDOS

ESTAMOS MUY AGRADECIDOS QUE

USTEDES ELIGIERON SER PARTE DE NUESTRA

OFICINA DENTAL PARA NINOS. PARA

QUE USTED GOCE DE SU VISITA HOY

TENEMOS INFORMACION DISPONISBLE PARA

CONTESTAR SUE PREGUNTAS. PARA

SERVILES MEJOR FAVOR DE LEER TODA LA

INFORMACION Y SI TIENE PREGUNTAS,

FAVOR DE PREGUNTAR A LA RECEPCIONISTA.

PARA SERVILES,

DR. GENE KOURI, DDS, MSD
DR. MORNA STAFFEL, DDS
& STAFF

BIEN VENIDOS A LA OFICINA DE LOS DR'S KOURI Y STAFFEL. COMO SERVICIO A SUS NECESIDADES Y A ESTA COMUNIDAD, ESTAMOS ACEPTANDO EL SEGURO DE MEDICAID. TOME POR FAVOR UN MOMENTO PARA LEER LAS POLISAS SIGUIENTES DE LA OFICINA.

1. NO PODEMOS GARANTIZAR LA HORA DE SU ESPERA DE SU VISITA. CADA NINO RECIBE EL CUIDADO PROFESIONAL, QUE EL REQUIERE, NO APRESURAMOS A LOS DOCTORES. SE SOLICITA SU PACIENCIA.

2. POR FAVOR REQUERDE QUE LOS NINOS DE CUATRO Y MAS IRAN A VER AL DR. Y LA HIGIENISTA SOLOS. NO HAY NINGUNA EXCEPCION A ESTA POLISA.

3. USTED DEBE TRAER CON TODAS LAS VISITAS LA TARJETA DE PAPEL DE MEDICAID QUE SE ENVIA A USTED DE AUSTIN. NO PODEMOS VER AL NINO SIN ESTA TARJETA.

4. SI USTED NO ES EL PADRE LEGAL DEL PACIENTE, DEBE TRAER LOS PAPELS DE CUSTODIA EL DIA DEL LA CITA.

5. LA PERSONA QUE TRAE AL PACIENTE DEBE PERMANECER EN LA AREA DE ESPERA EN CASO QUE UNA DECISION MEDICA NECESITE SER TOMADA.

6. HAY UNA POLISA ESTRICTA, SI USTED FALTA UNA CITA SIN DAR EL AVISO DE 24 HORAS, NO PODEMOS VER EL PACIENTE OTRA VES. DESPEDIRAN A LA FAMILIA ENTERA DE ESTA OFICINA.

7. USTED DEBE DE LLEGAR A TIEMPO A TODAS LAS CITAS. SI USTED ES MAS DE 15 MINUTOS TARDE, CAMBIAREMOS LA HORA DE USTED POR OTRA HORA. SI HAY UNA CITA DISPONIBLE PARA MAS ADELANTE ADENTRO EL MISMO DIA SERA OFRECIDA.

8. RESERVAMOS EL DERECHO DE RECHAZAR EL TRATAMIENTO A CUALQUIER PERSONA.

9. PEDIMOS QUE CADA ADULTO Y LOS NINOS PRACTIQUEN UNA MANERA COURTESIANA MIENTRAS QUE EN LA OFICINA.

10. LENGUAJE ASQUEROSO NO SERA TOLERADO EN ESTA OFICINA. DESPEDIREMOS LA FAMILIA DEL INDIVIDUO USANDO CAULQUIER FORMA DE LENGUAJE ABUSIVO O ASQUEROSO.

11. ES LA RESPONSABILIDAD DEL PADRE PONER LA NUEVA DIRECCION Y NUMERO DE TELEFONO DEL PACIENTE. SI NO PODEMOS HABLAR LE POR TELEFONO PARA CONFIRMAR LA CITA DEL PACIENTE, RESEVERAMOS EL DERECHO DE CANCELAR CUALQUIER CITA PROXIMA.

HE LEIDO Y ACEPTO SEGUIR ESTAS POLISAS QUE SON HECHAS PORT ESTA OFICINA

PADRE/ PARIENTE LEGAL FIRMA_____FECHA_____

Gene Kouri, D.D.S., M.S.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.
THE PRIVACY OF YOUR CHILD'S HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your child's health information to a physician or other healthcare provider providing treatment to your child.

Payment: We may use and disclose your child's healthcare information to obtain payment for services we provide.

Healthcare Operations: We may use and disclose your child's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your child's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification (including identifying or locating) a family member, your child's personal representative or another person responsible for your child's care, of your child's location, your child's general condition, or death. If you are present, then prior to use or disclosure of your child's health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's best interest in allow a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your child's health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's health or safety or the health or safety of others.

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 nation security activities. We may disclose to correction institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your child's health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your child's health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable fee for each page, a reasonable rate per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your child's health information in that format. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your child's health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restriction on our use or disclosure of your child's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your child's health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will b handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your child's 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.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 or your child's privacy rights, or you disagree with a decision we made about your access to your child's health information or in response to a request you made to amend or restrict the use or disclosure of your child's 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 may also 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 privacy of your child's 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.

Contact: **Dr. Gene Kouri**
ATTN: Privacy Officer
2921 Lackland Rd.
Fort Worth, TX 76116

Phone: 817 732 2821

REGISTRO DEL PACIENTE E HISTORIA CLÍNICA

Fecha_____ (POR FAVOR, ESCRIBA EN LETRA DE IMPRENTA) Teléfono Particular_____

Paciente_____
Apellido Primer Nombre Inicial Nombre Preferido

Dirección – Calle_____ Ciudad_____ Estado_____ Código Postal_____

Sexo: ☐ M ☐ F Edad_____ Fecha de Nacimiento_____ ☐ Soltero(a) ☐ Casado(a) ☐ Viudo(a) ☐ Separado(a) ☐ Divorciado(a)

Empleado(a) por_____ Ocupación_____

Dirección del Empleador_____ Teléfono del Empleador_____

Nombre del Cónyuge/Padre o Madre_____ Fecha de Nacimiento del Cónyuge/Padre o Madre_____

Cónyuge/Padre o Madre Empleado por_____ Ocupación_____

Dirección del Empleador_____ Teléfono del Empleador_____

¿Quién es responsable por esta cuenta?_____ Relación con el Paciente_____

No. de Seguro Social_____ No. de Seguro Social del Cónyuge/Padre o Madre_____

Nombre de la Compañía del Seguro Dental_____ Grupo Número_____

En caso de emergencia, ¿a quién se deberá notificar?_____ Teléfono_____

¿A quién podemos agradecer por habernos referido a Ud.?_____

HISTORIA CLÍNICA

Nombre del Médico_____ Fecha del Último Examen Físico_____

¿Ha tenido Ud. alguna vez algo de lo siguiente? (marque las casillas que correspondan):

- ☐ Soplo Cardíaco
- ☐ Presión Sanguínea Alta
- ☐ Presión Sanguínea Baja
- ☐ Problemas Circulatorios
- ☐ Problemas Nerviosos
- ☐ Radioterapia
- ☐ Articulaciones o Válvulas del Corazón Artificiales
- ☐ Reciente Pérdida de Peso
- ☐ Problemas de la Espalda
- ☐ Diabetes
- ☐ Enfermedades Respiratorias
- ☐ Epilepsia
- ☐ Dolores de Cabeza
- ☐ Hepatitis, Ictericia o Enfermedad del Hígado
- ☐ Cáncer
- ☐ Tratamiento Siquiátrico
- ☐ Prolapso de la Válvula Mitral
- ☐ Alergias a Anestesias
- ☐ Alergias a Medicinas o Drogas
- ☐ Alergias Generales
- ☐ Enfermedad de la Sangre
- ☐ Artritis
- ☐ Dieta Especial
- ☐ Glándulas del Cuello Hinchadas
- ☐ Fiebre Reumática
- ☐ Problemas de la Sinus
- ☐ SIDA/HIV
- ☐ Enfermedad de la Tiroides
- ☐ Embolia Cerebral
- ☐ Úlcera
- ☐ Enfermedades Venéreas
- ☐ Drogaadicción
- ☐ Hemofilia

¿Tiene Ud. alguna alergia a medicamentos, o ha tenido Ud. alguna vez una reacción adversa a algún medicamento?_____

Si la respuesta es afirmativa, ¿a qué?_____

¿Ha reaccionado Ud. alguna vez adversamente a un tratamiento médico o dental?_____

¿Está tomando Ud. actualmente algún medicamento?_____ Si la respuesta es afirmativa, ¿cuál?_____

¿Está Ud. bajo el cuidado de un médico? ☐ Sí ☐ No

¿Por el tratamiento de qué condiciones?_____

Si el paciente es un niño, ¿cuánto pesa el niño?_____

(Mujeres) ¿sospecha Ud. que está embarazada? ☐ Sí ☐ No ¿Está Ud. amamantando a un bebe? ☐ Sí ☐ No

¿Hay alguna otra cosa que nosotros debiéramos saber sobre su historia clínica?_____

La información de arriba es correcta y completa, a mi leal saber y entender, y se proporciona con el único objeto de que se use en mi tratamiento, para facturación, y para procesamiento ante el seguro de los beneficios a los que tengo derecho. Yo no haré responsable a mi dentista ni a ningún integrante de su personal por errores u omisiones que yo pueda haber cometido al llenar este formulario.

Fecha_____ Firma_____

(SIGUE AL DORSO)

TRASPASO DE LOS BENEFICIOS DEL SEGURO Y AUTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN

Yo, el suscrito, tengo seguro con _____
Nombre de la(s) Compañía(s) de Seguros

y traspaso directamente al Dr. _____ todos los beneficios del seguro, si los hubiere, que de otra manera son pagaderos a mí, por servicios prestados. Yo entiendo que soy financieramente responsable por todos los cargos incurridos, ya sea que son pagados por el seguro o no. Por el presente yo autorizo al doctor a divulgar toda la información que sea necesaria para asegurar el pago de los beneficios. Yo autorizo el uso de esta firma en todas las presentaciones que se hagan ante el seguro, ya sea que son hechas manualmente o electrónicamente.

_____ _____
Fecha *Firma*

CONSENTIMIENTO SOBRE MENOR/NIÑO

Yo, siendo el padre o tutor de _____ por el presente
Nombre del menor/niño
solicito del y autorizo al personal dental que preste los servicios dentales necesarios para mi niño, incluyendo pero no limitados a, radiografías y la administración de anestesia, que sean considerados aconsejables por el doctor, sea que yo esto presente o no en la cita dental cuando el tratamiento se lleva a cabo.

_____ _____
Fecha *Firma del Asegurado/Tutor*

ACUERDO FINANCIERO

Yo acepto que el pago de los servicios dentales se vence cuando se realiza el tratamiento, a menos que se hayan hecho otros arreglos. Yo estoy de acuerdo en que los padres o los tutores son responsables por todos los honorarios y servicios prestados para el tratamiento de un menor/niño. Yo acepto responsabilidad financiera total por todos los cargos no cubiertos por el seguro.

_____ _____
Fecha *Firma de Asegurado/Tutor*

ACTUALIZACIÓN DE LA HISTORIA CLÍNICA

¿Ha ocurrido algún cambio en su salud desde su última cita dental? ☐ Sí ☐ No

¿Para qué condiciones? _____

¿Está tomando Ud. algún medicamento nuevo? _____ Si la respuesta es afirmativa, ¿cuál? _____

_____ _____
Fecha *Firma del Paciente*

_____ _____
Fecha *Firma del Dentista*

Cual es su forma preferida de ser contactado: telefono _____ el texto de telefono _____ correo electronico _____

direcion de correo electronico: _____

Gene Kouri, D.D.S., M.S.D.

Acknowledgement of Receipt

Of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

Please print name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

The patient was offered a copy of the Notice of Privacy Practices. An attempt was made to obtain a signature on this Acknowledgement of Receipt for the notice. It could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Parent stated that a copy was received previously prior to treatment of sibling.
- ☐ Communications or language barrier.
- ☐ Emergency situation prevented obtaining acknowledgement.
- ☐ Other (Specify below).

_____

_____

Received by _____ Date _____
Staff Member