H.A. Dunlevy, D.M.D., M.S., PLLC.
Outer Banks Orthodontics
2224 S. Croatan Hwy, Suite 7
Nags Head, NC 27959
252.441.6683

Orthodontic Insurance Information

In order to assist you in determining your orthodontic insurance benefit, the following information is necessary:

Patient Name: _____Date of Birth: _____

Policyholder: _____ Date of Birth: _____

Address: _____

Policyholder's SSN: _____ Phone: _____

Policyholder's Employer: _____

Insurance Company: _____ Policy/Group #: _____

Policy ID (Insured): _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

Is patient covered under another plan? If so, please complete the following information:

Patient Name: _____Date of Birth: _____

Policyholder: _____ Date of Birth: _____

Address: _____

Policyholder's SSN: _____ Phone: _____

Policyholder's Employer: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

I, hereby authorize release of any insurance information relating to this claim:

Signature: _____ Date: _____

I hereby authorize payment of insurance benefits directly to Outer Banks Orthodontics:

Signature: _____ Date: _____

Please notify our office of any changes in your insurance policy as soon as possible.

OUTER BANKS
ORTHODONTICS

2224 S. Croatan Hwy, Suite 7
Nags Head, NC 27959
252.441.6683

AAOIC SUPPLEMENTAL INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as the "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes ❒ No ❒

Patient Name (Please print): _____

Patient/Parent Signature : _____

Date: _____

H.A. Dunlevy, D.M.D., M.S., PLLC.
Outer Banks Orthodontics
2224 S. Croatan Hwy, Suite 7
Nags Head, NC 27959
252.441.6683

Authorization for Release of Information

Patient Name: _____Date of Birth: _____

You have the right to request that Outer Banks Orthodontics communicate with you by alternative means or at alternate locations. This form is optional and does not expire. Your request will be in effect until you notify Outer Banks Orthodontics of a change in writing. We will accommodate all reasonable requests.

I _____ , hereby consent and state my preference to have my request that my medical and/or billing information be communicated to me by the following means (check all that apply):

❒ Home Phone _____

❒ You may leave a message/send texts with **medical information** on voice mail/answering machine

Cell Phone _____ Work Number _____

❒ You may leave a message/send texts with **appointment reminders** on voice mail/answering machine

Cell Phone _____ Work Number _____

❒ Email and/or text communication - I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Photos taken by staff (Example: Pre/Post Procedure) - Photos/xrays taken by our office may be mailed to patient guardian and/or dentist

❒ May be posted in office ❒ May be posted on our website (winning a contest or other activities

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SME messaging regarding my medical care might be intercepted and read by a third party.Outer Banks Orthodontics does not recommend the use of email or text messaging to communicate about my medical care and will not initiate communication with me via email or SMS messaging, unless sent through our secure portal.

Signature: _____ Date: _____

Please notify our office of any changes in your insurance policy as soon as possible.

OUTER BANKS ORTHODONTICS

2224 S. Croatan Hwy, Suite 7
Nags Head, NC 27959
252.441.6683

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of
(Responsible Party)
Privacy Practices.

Patient Name: _____

Responsible Party Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, however acknowledgement could not be obtained due to:

❒ Individual refused to sign

❒ Communication barriers prohibited obtaining the acknowledgement

❒ An emergency situation prevented us from obtaining acknowledgement

❒ Other (Please specify): _____

H.A. Dunlevy, D.M.D., M.S., PLLC.
Outer Banks Orthodontics
2224 S. Croatan Hwy, Suite 7
Nags Head, NC 27959
252.441.6683

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 _____

Print Patient Name: _____

Parent/Guardian and Relationship to Patient: _____

_____

Please note: It is helpful to list below any family members or persons that could be accompanying the patient to appointments. Also if there is SPECIFIC information you DO NOT want disclosed, such as financial information to anyone listed below, please notify our office HIPAA Compliance Coordinator, who can make additiona notations of this.

❒ I, _____ hereby authorize the following person/persons to receive health treatment and financial information regarding the above name patient. Please note: It is helpful to list below any family members or persons that could be accompanying the patient to appointments.

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

❒ NO, DO NOT DISCLOSE ANY TREATMENT INFORMATION (please initial here) _____

SIgnature: _____