TMJ & Facial Pain Center

Wesley E. Shankland, II, D.D.S., Ph.D., Inc.

158 A Commerce Park Drive ● Westerville, Ohio 43082
614/794-0033 – Office ● 614/794-2291 - Fax

Welcome to Our Office!

We want to welcome you to our office and look forward to serving you! The following information is important in assisting you with planning your first visit to our office. Please feel free to contact us with any questions. Our office hours are: **Monday and Tuesday 7 am to 6 pm, and 8 am to 2 pm on Wednesdays.**

DIRECTIONS and ACCOMMODATIONS A map to our office is enclosed. If traveling from outside Ohio, we are in the Eastern Standard time zone. Several area hotels provide courtesy rates for our patients, and we will provide that information to you.

MEDICAL HISTORY A *Personal History* and *HIPAA Consent form* are enclosed. **Please bring the completed forms to your appointment.** In addition, bring past medical records, x-rays, splints, or information you feel is pertinent for your evaluation. Your spouse or partner may accompany you to your appointment as successful treatment begins with family involvement. For their safety and in compliance with state law, *accompanying children are not permitted in the treatment room.*

CANCELLATIONS Kindly consider the time reserved for you. A fee may be charged for failure to show for your appointment. If you need to change or cancel your appointed time, contact us during normal office hours so we can reappoint your time to allow that time for another patient. We regret that appointments missed without notification will not be re-appointed.

INSURANCE TMJ & Facial Pain Center does not participate with your medical carrier. Please contact your primary care physician for out-of-network referrals. We will gladly file claims or provide you with a ready-to-file form. Patients with secondary insurance plans will need to be responsible for filing claims to the secondary carrier.

MEDICARE Dr. Shankland **does not** participate with Medicare medical/dental plans. Medicare recipients are required to sign a *private contract form* stating that neither the patient nor the provider will file claims to Medicare for any reason, as stated in the contract. Patient will be responsible for full payment at the time of service, not reimbursable from Medicare.

FEES and PAYMENT PLANS The fee for the initial exam will be payable at the time of the visit. This fee is for the exam only and *does not* include x-rays, scans, diagnostic injections, treatment, or additional procedures that may be performed. We welcome all major credit cards, check or cash for your convenience. We also offer Care Credit, a flexible payment program designed for healthcare expenses.

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PATIENT INFORMATION

Patient Name: _____ Birthdate: _____

Street: _____ City:_____ State:_____ Zip: _____

Cell: _____ Home:_____ E-mail: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Who referred you to our office?: _____

HEALTH HISTORY

Suspected Disorder(s) Circle all that apply:

Obstructive Sleep Apnea	Restless Leg Syndrome	Insomnia	Narcolepsy	Other

Height: _____ Weight: _____ Medical allergies: _____
List current medications: _____

	Signs and Symptoms		Medical History
	Excessive Daytime Sleepiness		None
	Difficulty Staying Asleep		Heart Disease
	Gasping / Choking		Hypertension
	Take frequent naps		Respiratory Problems
	Witnessed Apneas		Stroke
	Headaches		Diabetes
	Snoring		Depression/Anxiety
	Grind and/or clench your teeth		Impaired Cognition
	Difficulty staying awake/ Fall asleep when driving		Mood Disorder (lack of focus)
	Other:		Other:

SLEEP DISTURBANCE EXAM

1. Have you had a polysomnogram (test at a sleep lab)? Y N
   a. Name of Lab, if yes: _____
2. Have you been treated previously for sleeping disorders? Y N
3. If treated previously, what therapy was used? (Circle all that apply): C-PAP, BiPap, Surgery, Oral Appliance, Medication, Diet, Other:_____

EPWORTH SLEEPINESS SCALE

Please use the following scale to choose the most appropriate number for each situation:

0 = You would never doze
1 = A slight chance of you dozing
2 = A moderate chance of you dozing
3 = A high chance of you dozing

Situation		Scale (0-3)
1.	Sitting and reading	_____
2.	Watching TV	_____
3.	Sitting, inactive in a public place, (e.g. theater, or meeting)	_____
4.	As a passenger in a car for an hour without a break	_____
5.	Lying down to rest in the afternoon	_____
6.	Sitting and talking with someone	_____
7.	Sitting quietly after lunch, without alcohol	_____
8.	In a car, while stopped for a few minutes in traffic	_____
	TOTAL:	**_____**

INSURANCE

Insured's full name:_____ DOB: _____ SSN: _____

Primary Medical:_____ Relationship: Self/Spouse/Child

Claims Address: _____ Phone: _____

Employer: _____ ID #: _____ Group: _____

FINANCIAL and INSURANCE CONSENT

I understand that Dr. Shankland ***does not participate with my medical insurance provider*** and I am fully responsible for any and all treatment provided by Dr. Shankland and the TMJ & Facial Pain Center. I authorize the ***release of all medical or other information*** necessary to process insurance claims if I request this Facility to submit claims on my behalf.

Signature: _____ Date: _____

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FINANCIAL POLICY

We appreciate that you have chosen Dr. Shankland to provide excellent service for your dental needs. And, we know how important financial planning is to successful treatment. Below you will find our financial policy, payment options, and insurance information.

- **Cash, Check, Credit Cards**
  Our office accepts cash, check, Health Saving Cards, and all major credit cards (Visa, Mastercard, Discover, American Express) for payment.

- **CareCredit Financing**
  CareCredit is an excellent resource for healthcare costs. Upon credit approval, there are flexible interest-free and low-interest extended financing. Please go to www.carecredit.com

- **Options Dental Assurance Discount Plan**
  Options Dental is our in-office savings membership plan. This plan is designed for those who do not have a traditional dental plan. For a low yearly membership rate, our plan includes two routine cleanings, bitewing x-rays once per year, 15% off basic dental procedures such as fillings, basic dental services, panoramic x-rays, and 10% off major services such as crowns, bridges and dentures.

- **Dental Insurance**
  Our office participates with: Aetna, MetLife, Delta Dental, Connections Dental, United Concordia, Guardian (Some listed dental plans may use savings plans or are administered by another carrier that we do not participate with). Please check with your dental plan for specific provider participation with our office.

- **Medical Insurance**
  Our office does not participate with medical insurance plans. Inquire with your policy if they offer a network exception to out-of-network providers. Your plan may require a prior authorization or pre-determination for your treatment plan. **It is the patient's responsibility to contact their insurance plan for specific benefit information. Payment will be expected at the time services are performed.**

- **Medicare and Medicaid**
  Dr. Shankland is an **"opted out"** provider with Medicare and therefore, we enter into a private payment contract between patient/doctor and agree that neither party can submit claims to Medicare. We do not participate with any Ohio Medicaid program.

Notice of Privacy Policies

TMJ & Facial Pain Center, Inc.

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to TMJ & Facial Pain Center, Inc.

TMJ & Facial Pain Center, Inc.'s Legal Responsibilities: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and becomes effective 04/01/2003.

We reserve the right to modify our privacy policies and the terms of this notice at any time and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contact us is at the bottom of this notice.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated, or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without you're written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others, we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counterintelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a *Protected health information Access Form* by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you an initial fee of fifteen dollars, one dollar a page for the first ten pages, fifty cents per page for pages eleven through fifty and twenty cents per page for pages fifty-one and higher. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost-based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost-based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject you request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a 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 Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Contact Person's Name: Sherry McCutcheon

Practice Name: TMJ & Facial Pain Center

Address: 158 A Commerce Park Drive,
Westerville, Ohio 43082

Phone: 614/794-0033 Fax: 614/794-2291

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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA), C.F.R. Parts 160 and 164. The notice of HIPAA policy that you received describes your rights as a patient under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

AUTHORIZATION: By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have a right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- My protected health information may be disclosed or used for treatment or consult, billing, insurance billing, insurance billing or payment or other purposes I may direct.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.
- This authorization will remain effective unless I revoke this authorization in writing.

YES **NO** May we phone, email or text to confirm appointments?
YES **NO** May we leave a message on your answering machine at home or your cell phone?
YES **NO** May we discuss your medical condition with any family member? If yes, name family members allowed: _____
YES **NO** I authorize the release of my complete health record including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse or other: _____

I authorize the release of my complete health record including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse or other _____, with the exception of the following information: ___ Mental healthcare; ___Communicable disease; ___HIV or AIDS; ___Treatment of Alcohol or Drug Abuse; Other:_____.

I have been given a copy of the HIPAA Policy, have read the HIPAA Privacy Authorization. By signing this form, I consent to your use and disclosure of my protected healthcare information.

_____ _____
Printed name of Patient or Personal Representative Relationship

_____ Date: _____
Signature of Patient or Personal Representative

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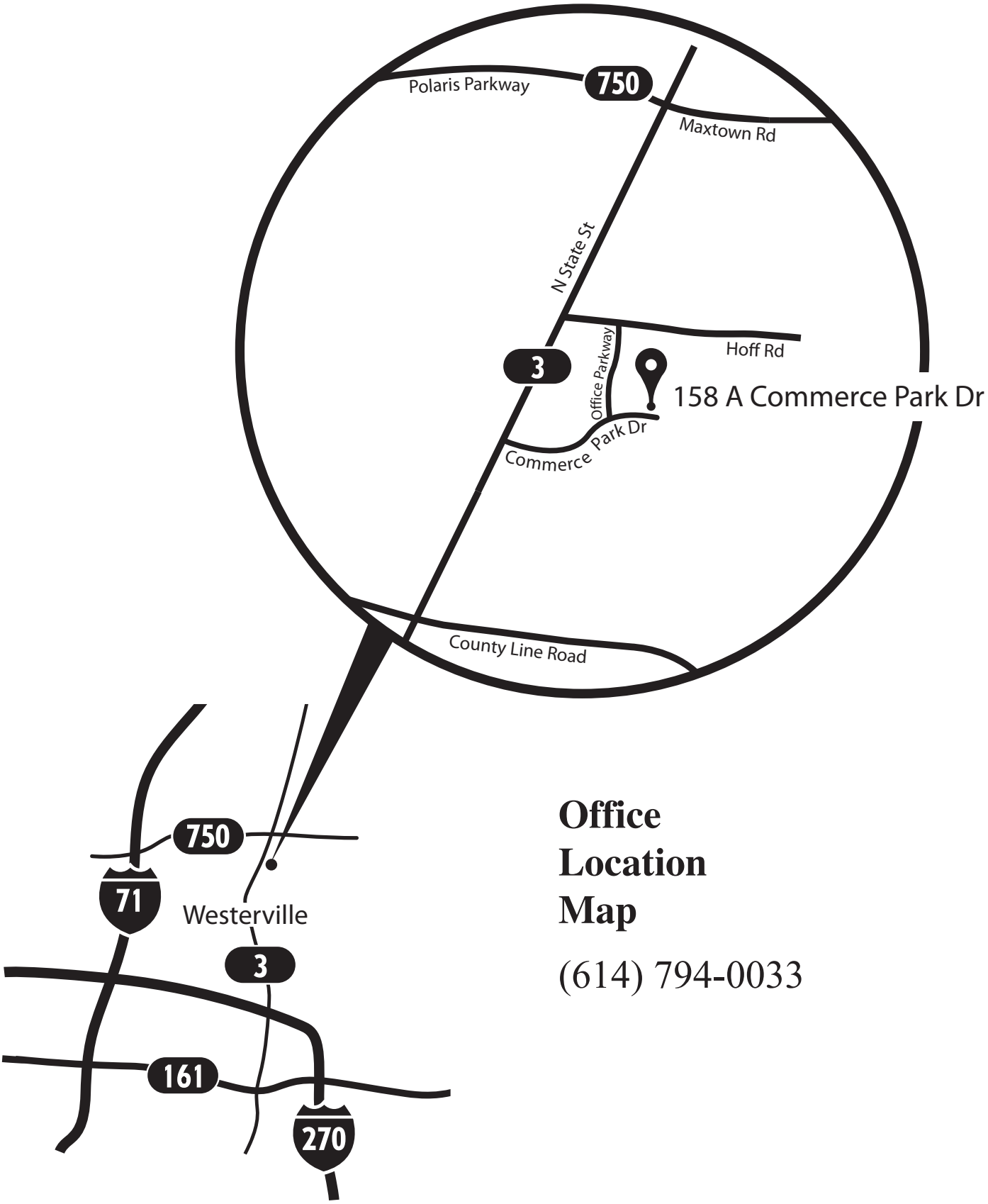

Office Location Map

(614) 794-0033

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