Dr. James E. Cauley
Affordable Dentures and Implants
1123 Ashley River Rd Charleston, SC 29407
(843) 402-9595

WELCOME LETTER

Dear Potential New Patient,

Please let me welcome you to our ***Affordable Dentures and Implants*** in Charleston-West Ashley, South Carolina. We are honored that you would choose our practice to assist you in achieving your oral health goals. Although we are a Member Practice of the ***Affordable Dentures and Implants*** network (Affordable Care Inc.,) this practice is independently and solely owned by the general dentist **James E. Cauley, DMD, FICOI**. Dr. Cauley has over two decades of dental experience and works hard to deliver the highest level of care for you. He will be your primary dental care provider in this office. He and his associate doctors will make all decisions regarding treatment recommendations and the delivery of your care. Occasionally, you may be seen by one of our associate doctors if Dr. Cauley is not in the office that day (a rare occurrence.) All of the caregivers and staff in this practice are committed to excellence.

Our goal is to deliver an excellent quality of care at a price that is significantly lower than other providers in our area. In order to meet this goal we are able to negotiate dramatically lower costs of materials and services that we are required to purchase to treat you through our affiliation with the ***Affordable Dentures and Implants*** Network. However, it is imperative that we operate efficiently in the rendering of your care to be able to continue to offer excellent dental treatment at an incredibly lower price point to this community. We structure the timing and scheduling of our evaluations and procedures very carefully.

What does this mean to you? How will your experience possibly differ from dental visits that you may have had in the past with other providers.

1. **We offer "BLOCK SCHEDULING"** That means that you have a "check in" time to queue up for the next step in the process, along with other patients who have the same " block" sign in time. **WE DO NOT OFFER SET APPOINTMENTS.** You must be checked in and ***in the waiting area*** at the time we advise you to be there. If you are late, you will be placed in the next available "block" of time for your procedure or be rescheduled for another day if you prefer. Please make sure that you are clear on how this works. Patients will be called to the treatment area based upon their required procedure and the available treatment area that will accommodate that particular requirement. We have a large clinical area, but many of the treatment areas only accommodate specific types of care and procedures. You may see someone enter the clinical area before you who arrived at a later time. Rest assured, we have not forgotten you. Call back times are based upon previously outlined reason.
2. **Multiple Procedures Within the Same Day (Multiple Block Check In Times.)** Many of our procedures and service offerings require a full day of commitment from you over multiple same

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day clinic visits. If you are not prepared for this please inform our Front Desk Staff now and schedule for another day when you are prepared to dedicate the required time for correcting your dental problems. Also, make your loved ones and transportation providers who are accompanying you aware of the time requirements. Please consider that for many of you we are addressing issues that took months, years, and frequently decades to develop. Some of you will have complex treatment needs. We urge you to remain patient with Dr. Cauley, our on site Laboratory, our clinical assistants, and the administrative staff. Everyone is working towards and committed to making sure that your needs are taken care of as quickly as is feasible. Regardless of the schedule, our chief mandate is to render the best possible care in order to obtain the best treatment outcomes for you. We take what we do here very seriously.

3. **We are caring for Human Beings**. It is a goal of our practice to be respectful of everyone's valuable time. However, we are caring for people. Often the procedures are complex and demanding. Frequently, unexpected findings lead to longer than anticipated treatment times. As stated earlier, our primary obligation is to make sure that procedures are carried out with the highest level of care with the goal of an excellent outcome of treatment. This may mean an extra 30 minutes or an hour of treatment time that was not expected. Please take comfort in knowing when **YOU** are the patient under care, **NO ONE** will rush through your treatment just to achieve a scheduling goal. Please resist the urge to disturb my administrative staff with questions about how much longer until you are called for care. First , they really don't know. Second, they have been instructed by me to tell you that we will get you back as soon as possible. This is completely out of their control, and they are quite busy facilitating care for other patients.

Now that we have some explanation of how things work here at ***Affordable Dentures and Implants*** in Charleston-West Ashley South Carolina, we want to make you aware that we have some of the most modern diagnostic and imaging tools available today. We are a leader in dental implants and tooth replacement throughout the United States. There is an on site full service dental laboratory here that is dedicated to only serving the needs of Dr. Cauley and his dental practice. This allows us to deliver Dentures, Partials, and Implants to you in a day or two, that would take weeks and multiple appointments to receive in a traditional dental office. We look forward to impressing you with our healthcare skills and customer service abilities.

Sincerely,

James Cauley

Dr. James E. Cauley

Owner and Care Provider

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WELCOME LETTER ACKNOWLEDGEMENT

IN ORDER TO BEGIN TREATMENT, PLEASE RETURN THIS COMPLETED AND SIGNED ACKNOWLEDGEMENT TO THE FRONT DESK STAFF. WE MUST HAVE THIS ACKNOWLEDGEMENT IN ORDER FOR YOU TO RECEIVE YOUR NEW PATIENT INFORMATION PACKET OR THE APPROPRIATE FORMS REQUIRED TO UPDATE YOUR RECORD.

I,__________________________have read and do fully understand the information conveyed in the Welcome letter from Dr. Cauley and Affordable Dentures and Implants. Please proceed with processing me to become or continue on as a patient in this practice. If in the future I have questions about the information contained in the Welcome Letter, another copy will be provided for my review and understanding.

Name: (printed)____

Signature:____________________________Date:__________________

Witness:_____________________________Date:__________________

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BIOGRAPHICAL HISTORY/ INSURANCE

Patient:____ Gender: Male Female
(First Name) (Middle Name) (Last Name)

Date of Birth:____-________-_________ Social Security Number:______/_________/________

Home Address:____

City:________________________ State:______________________ Zip:______________________

Home Telephone:______________________________ Work Telephone:__________________________

Mobile Phone:________________ Does this phone receive text messages? YES NO
(We may text you during your visit for long treatment days if your prosthesis is ready early)

Who may we contact in case of Emergency?:___________________ Phone Number:_______________

Race: (Circle One)
African American Asian American Caucasian/ White Hispanic Other

Have you received treatment in our office previously? YES NO

How did you hear about us?

Newspaper/ Magazine | Internet
Facebook | TV
Brochure/ Mail | Friend/ Relative
Other Doctor/ Outside Agency

Do you have dental insurance or medicaid? YES NO

Name of Insurance:_______________________ Employer:_________________________________

Are you the primary? YES NO If not, who is?_________________ Social Security:_____-______-______

Primary date of birth: ______/______/_____ If a replacement, what is the age of prosthesis?______ years

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MEDICAL/ DENTAL HISTORY

Why are you here to see us today?

____

____

Are you in pain at the moment? YES NO (How much pain on 1 to 10 scale?__________)

Are you currently under the care of a physician for any condition? YES NO

Do you CURRENTLY have any of the following medical conditions?
Please answer with **YES** or **NO**. **DO NOT LEAVE BLANKS:**

Cardiovascular/ Blood

______High Blood Pressure
______Irregular Heartbeat
______Abnormal Bleeding
______Anemia
______Angina Pectoris
______Artificial Heart Valve
______Blood Disorders
______Congenital Heart Defect
______Hemophilia
______Heart Ailments/ Murmur
______Low Blood Pressure
______Mitral Valve Prolapse
______Pace Maker
______Sickle Cell Anemia
______Stroke
______Leukemia

Respiratory

______Asthma
______Difficulty Breathing
______Shortness of Breath
______Emphysema
______Lung Disease
______Respiratory Disease
______Sinus Problems
______Lung Cancer
______COPD

Muscoloskeletal

______Joint Replacements
______Osteoporosis
______Broken Bones
______Muscle Tears or Sprains
______Arthritis
______Osteopenia

Other

______HIV/ AIDS
______Cancer
______Colitis
______Diabetes
______Intestinal Disease
______Hepatitis A/B/C
______Dialysis/ Kidney Dis.
______Psychiatric Problems
______Substance Abuse
______Tuberculosis
______Thyroid Dis.
______Venereal Dis.
______Alzheimer's
______Eating Disorder
______Epilepsy

Do you suffer from any other medical condition(s) not listed above? YES NO

IF YES PLEASE EXPLAIN:____

____

____

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MEDICAL/ DENTAL HISTORY (PAGE 2)

Please list all of the medications that you take:

For Pain:____

For Blood Pressure:__________________________________

For Heart Problems:__________________________________

For Diabetes: _____________________________________

Other medications or supplements:___________________________

____

Do you have any allergies? _______________________________

____

Do you use recreational drugs? YES NO If so, which ones?________________

____

Have you ever had IV medications for osteoporosis? YES NO

Do you use tobacco products? YES NO If yes please **CIRCLE** which type:

Cigarettes Cigars Dip Snuff Chewing tobacco Pipe How much?__________

What Pharmacy do you use?:

Name: ______________________________________

Address:______________________________________

Phone Number:__________________________________

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ANSWERED HONESTLY AND ACCURATELY.

PATIENT SIGNATURE:______________________________DATE:____________

Notice of Privacy Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE BECAME EFFECTIVE SEPTEMBER 23, 2013.

Our commitment to your privacy

We understand that information about you and your health is very personal, and we are committed to protecting the privacy of this information. Each time you visit an affiliated dental practice providing Affordable Dentures®, we create a record of the care and services you receive. This record is necessary to provide you with high quality care and ensure we are in compliance with certain legal requirements.

This Notice will describe the ways in which we may use and disclose your medical information. This Notice applies to your personal medical information, consisting of any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

We reserve the right to change the terms of this Notice at any time. Any revision to this Notice will be applicable to all medical information we already have about you, as well as any of your medical information that we may receive, create, or maintain in the future. We will post a copy of our current Notice in a prominent location at our dental office. A copy of the current Notice in effect will be available at the Front Desk area of our dental office and on our website.

How we may use and disclose health information about you

We may use your health information, or disclose it to others, for a number of different reasons. This Notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Treatment. We will use your health information to provide you with medical care and services. This means that our employees, staff, and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to make decisions about your care. For instance, a dentist may read your dental chart in order to care for you properly. We will also disclose your information to others who need it in order to provide you with medical treatment or services. For instance, we may send your doctor the results of an x-ray we perform.

2. Payment. We will use your health information, and disclose it to others, as necessary to obtain payment for the services we provide to you. For instance, an employee in our business office may use your health information to prepare a bill. And we may send that bill, and any health information it contains, to your insurance company. We may also disclose some of your health information to companies with whom we contract for payment-related services.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this dental practice. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other patients to plan what services we need to provide, expand, or reduce. We may disclose your health information as necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, management services providers, and consultants, for instance.

4. Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by Medicaid. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect, or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. Law Enforcement. We may disclose your health information for law enforcement purposes if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believed may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime. We must also disclose your health information to a governmental agency investigating our compliance with privacy regulations.

8. Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may also disclose the health information to the appropriate foreign military authority if you are a member of a foreign military. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, counter-intelligence and protection of the President, other authorized persons or foreign heads of state or to conduct special investigations. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your health information to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance).

9. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. Family and Friends / Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a mem-ber of your family, a relative, a close friend or any other person you identify, your health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

11. Research. We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

12. Information to Patients. We may use your health information to provide you with additional information. This may include sending appointment reminders to your address. This may also include giving you information about treatment options or other health-related services that we provide.

13. Business Associates. We may share your health information with another company that performs business services for us such as management companies. If so, we will have a written contract to ensure that this company also protects the privacy of your health information.

14. Emergencies. We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your written authorization. If this happens, we will try to obtain your written authorization as soon as we reasonably can after we treat you.

15. Lawsuits and Disputes. We may disclose your health information if required by law or an order of a court that is handling a lawsuit or other dispute.

16. Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

17. Data Breach Notification Purposes. We may use or disclose your personal health information to provide legally required notices of unauthorized access to or disclosure of your personal health information.

18. Disaster Relief. We may disclose your health information to disaster relief organizations that seek your health information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

19. Uses and Disclosures if You are Deceased. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, who were involved in your care of payment for health care prior to your death, your health information that is relevant to that person's involvement.

Your Written Authorization is Required for Other Uses and Disclosures.
The following uses and disclosures of your health information will be made only with your written authorization:

1. Uses and disclosures of your health information for marketing purposes; and,
2. Disclosures that constitute a sale of your health information.

Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to the Privacy Office noted below or our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But, the disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Health Information Rights.
Although your dental record is the physical property of our dental practice, the information belongs to you. You have certain rights with respect to your information as described below. If you wish to exercise your rights, you may write directly to the Privacy Office at the address stated at the end of this Notice.

1. Right to request a restriction on certain uses and disclosures of your information. You have the right to request a restriction or limitation on the medical information we use and/or disclose about you for treatment, payment, or healthcare operations. Additionally, you have the right to request that we limit the information we disclose about you to someone who is involved in your care or the payment for your care. For instance, you can request that we refrain from disclosing information about a procedure that you had or a treatment you were given.

   We are not required to agree to your request. However, if we do agree, we will comply with your request so long as the information is not necessary to provide you emergency care.

   Your request must be in writing, delivered to the address provided above, and must include a description of the information you wish to limit, whether you want to limit the use, disclosure, or both, and to whom you want the limitations to apply.

2. Right to inspect and/or request a copy of your dental record. You have the right to inspect and/or receive copy any medical information maintained about you that may be used to make decisions about your care. Typically, this will include your dental and billing records.

   In order to inspect and/or receive a copy of your medical information, you must submit your request, in writing to our dental practice in care of the Privacy Office at the address noted below. We may charge a reasonable fee for this service based on our cost of complying.

   In very limited circumstances, we may deny your request to inspect and/or receive a copy of your dental information. However, if your request is denied, in some cases you may request that the denial be reviewed. Such reviews are performed by an independent licensed healthcare professional chosen by the owner of our dental practice. We will comply with the outcome of the review.

3. Right to an Electronic Copy of Electronic Medical Records. If your health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your health information in the form or format you request, if it is readily producible in such form or format. If the health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

4. Right to request an amendment to your dental record. If you believe the information we maintain about you is incorrect or incomplete, you may request that we amend the information. In order to request an amendment, you must submit a written request, as described above, indicating the specific information you wish to be amended and providing the reason supporting the request. Failure to put your request in writing or provide supporting reasoning is likely to result in a denial of your request. We may also deny your request if you ask us to amend information that:

   Is accurate and complete.
   Is not part of the information which you would be permitted to inspect or receive a copy.
   Is not part of the medical information maintained by our dental practice.
   Was not created by us, unless the individual or organization that created the information is no longer available to make the amendment.

5. Right to request alternative communications. You have the right to request that we communicate with you about medical matters in a certain manner or at a certain location. For example, you may request that we limit our communications with you to contact at work or at home. Your request must be in writing, as described above, and must specify the manner in which or the location at which you wish to be contacted. All reasonable requests will be accommodated.

6. Right to receive an accounting or a list of prior disclosures of your personal health information. You have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to April 14, 2003. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to directly to the Privacy Office at the address stated at the end of this Notice.

7. Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured health information.

8. Out of Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

9. Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website, www.AffordableDentures.com. To obtain a paper copy of this notice, please write to the Privacy Office at the address listed at the end of this Notice. Copies of the current Notice in effect will also be available at the Front Desk area.

Questions and Complaints
If you want more information about our privacy policies or have questions or concerns, please speak with the Practice Owner at the dental practice or call or write to the Privacy Office noted at the end of this Notice.

Changes to this Notice. We reserve the right to change this Notice and make the new Notice apply to health information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

If you are concerned that we may have violated any of your rights, or you disagree with a decision we made about access to your dental information or in response to a request you made in accordance with your rights and the above instructions, you may complain to us in writing delivered to:

Privacy Office
Affordable Dentures
1400 Industrial Drive
Kinston, NC 28504

Telephone: 1-800-DENTURE (1-800-336-8873)

You may also file a complaint directly with the Secretary of the U. S. Department of Health and Human Services at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. We will not retaliate in any way if you choose to file a complaint with us or the Secretary.

If you would like a copy of this Notice for your personal records, please ask for a copy at the Front Desk. We will also have copies generally available in the Front Desk area of our dental practice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature *Date*

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Relationship________________________ Name ______________________________

Relationship________________________ Name ______________________________

Relationship________________________ Name ______________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

____

____

Employee signature Date