

Your First Visit

We at Seda Perio are committed ensuring that you know exactly what to expect at your first visit to our practice.

When you arrive for the first time, we will process the information you have filled out on your New Patient Forms (these are usually sent out or emailed prior to your visit). In order to perform this in a timely manner and better serve you, we kindly ask that you have this information filled out ahead of time. This will ensure that your appointment is as targeted as possible, with minimal waiting time for you.

Once we have processed the information from your forms, one of our caring assistants will help you get seated in the consultation room. There will be some questions to review your medical history, dental history, as well as your chief concern.

Upon completion of the medical history review, Dr. Seda will come in, introduce himself, be updated on your specific situation, and perform a Complete Periodontal Exam. He will look at all areas of the mouth, including the area of main concern. He will most likely have notes from your dentist about your situation, and possibly even contacted your dentist if he has any questions, all in preparation for your visit.

As for the financial aspect of your visit, there is a \$189.00 fee for the comprehensive evaluation. We accept most Dental PPO plans, cash, check or credit card. We are contracted with Delta Dental ONLY. As for all other insurance plans, we ask that you contact them to see if your visit is eligible to be covered, as they are more responsible to you as the patient. We have found that they provide more current and accurate information to you the insured party, rather than to us.

If for any reason your insurance does NOT cover your visit, you will be responsible for the balance.

We are very delighted to meet you, and please do not hesitate to contact our office with any questions or concerns prior to your first visit. Please allow a minimum of 1 hour for your appointment. It means the world to us that you have as positive of an experience as possible, and we are willing to do whatever it takes to ensure that.

Please sign and date that you have read and acknowledge all of the written statements above

Patient Signature

Date

Legal Guardian Signature

Date

MICHAEL SEDAGHATFAR, D.M.D., M.S.
PRACTICE LIMITED TO PERIODONTICS AND IMPLANT DENTISTRY

NEW PATIENT INFORMATION RECORD

(circle one): Mr. Dr. Mrs. Ms. Miss NAME:		REFERRED BY:	
ADDRESS:	CITY:	ZIP:	HOME TEL. NO.:
EMPLOYER:	OCCUPATION:	BUS. TEL. NO.:	
DATE OF BIRTH:	SOC. SEC. NO.:	MEDICAL DOCTOR:	PHONE:
E-MAIL ADDRESS:			
SPOUSE INFORMATION			
NAME:			
EMPLOYER:	ADDRESS:	CITY:	ZIP:
POSITION:	PHONE:		EXT.:
EMERGENCY CONTACT:	PHONE:		EXT.:

MY DENTAL INSURANCE INFORMATION
INSURANCE CO.:
POLICY NUMBER:
Date of Birth:
Social Security #:
Insurance Carrier Address:
Insurance Carrier Phone:
Employer:

MY SPOUSE'S DENTAL INSURANCE INFORMATION
INSURANCE CO.:
POLICY NUMBER:
Date of Birth:
Social Security #:
Insurance Carrier Address:
Insurance Carrier Phone:
Employer:

☐ I AM NOT COVERED BY ANY DENTAL INSURANCE (EITHER MINE OR OTHER FAMILY MEMBER'S) AT THIS TIME.

I hereby authorize Michael Sedaghatfar, D.M.D., M.S., or their staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Michael Sedaghatfar, D.M.D., M.S. of the medical and dental insurance benefits otherwise payable to me, for the services rendered to me by either doctor or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Academy of Periodontology, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Michael Sedaghatfar, D.M.D., M.S..

Appointments: Your appointment time is reserved for you. We will do our best to be prompt and to estimate the time of your visit, but emergencies do arise. Please allow enough time for us to do our best dentistry for you. We believe that quality is more important than speed. There is a charge for missed appointments or cancellations without 48 hours notice, 48 hours for hygiene and for surgical appointments, 72 hours is required.

Payment: I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the Financial Department. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

I acknowledge that I have read and understand the above statements and policies, and that this authorization remains valid and effective from the date of signing until revoked in writing.

Signature of Patient or Patient's Legal Guardian

Date of Signature

Medical History

Your general health constitutes an important factor, and in combination with other causes, may influence the course of periodontal disease. To assure your health during therapy and to assist in establishing a complete diagnosis and successful treatment, please complete this confidential form.

Would you describe your general health as good? Yes ☐ No ☐

Are you currently being treated by a physician? Yes ☐ No ☐

If so, for what condition? _____ Date of your last physical exam _____

Are you now taking or have you been taking any drugs or medications within the last year? Yes ☐ No ☐

If so, please list _____

Are you now taking or have you ever taken Bisphosphonate medications (Fosamax, etc.)? Yes ☐ No ☐

Have you had a major illness or been hospitalized within the last 3 years? Yes ☐ No ☐

If so, please describe _____

Do you smoke or use tobacco regularly? If so, how much? _____ (Packs per day) Yes ☐ No ☐

Do you have any history of tobacco use? Yes ☐ No ☐ Quit date _____

Please check if you are sensitive or allergic to any of the following: _____

- | | | |
|--|---------------------------------------|---|
| ☐ Penicillin | ☐ Barbiturates | ☐ Latex Allergy |
| ☐ Other Antibiotic | (sleeping pills, sedatives) | ☐ Codeine |
| ☐ Novocain or other Dental Anesthetic | ☐ Sulfa Drugs | ☐ Aspirin |
| ☐ Nitrous Oxide | ☐ Demerol | ☐ Natural Remedies |
| ☐ Recreational Drugs | ☐ Other: _____ | |

Please check if you have ever had any of the following: _____

- | | | |
|---|---|---|
| ☐ Heart Disease | ☐ Artificial Transplants or Implants | ☐ Venereal Disease (Syphilis or Gonorrhea) |
| ☐ Heart Attack | (Pacemaker, Heart Valve, Hip Joint) | ☐ Severe or Frequent Headaches |
| ☐ Stroke | ☐ Blood Disorders | ☐ Nervous Disorders/Psychiatric Care |
| ☐ Heart Murmur | (Anemia, Leukemia, Hemophilia) | ☐ Arthritis |
| ☐ Rheumatic Fever | ☐ Blood Transfusion | ☐ Lung Disease (TB, Asthma, Emphysema) |
| ☐ Abnormal Blood Pressure (high/low) | ☐ Epilepsy | ☐ Sinus Trouble |
| ☐ Diabetes | ☐ Fainting Spells/Convulsions | ☐ Skin Diseases |
| ☐ Ulcers, Stomach Problems | ☐ Tumors, Malignancies or Cancer | ☐ Eye Disease (Glaucoma, Cataracts) |
| ☐ Hepatitis, Liver Disease/Jaundice | ☐ Chemotherapy Treatment | ☐ Ear Trouble, Ringing in Ear, Dizziness |
| ☐ Kidney Disease or Infections | ☐ X-Ray, Radium or Cobalt Treatment | ☐ Severe Stress |
| ☐ HIV, AIDS or ARC | ☐ Herpes | |

WOMEN: Are you nursing? ☐ Yes ☐ No Pregnant? ☐ Yes ☐ No Delivery Date _____

Taking oral contraceptives? ☐ Yes ☐ No

Is there any other information about your health which might be important for us to know? _____

Dental History

Date of last cleaning _____

Have you ever had root planing (deep scaling) done? ☐ Yes ☐ No

Have you had previous periodontal surgery? ☐ Yes ☐ No

If so, when? _____

Have you ever had any complications following any dental treatment? ☐ Yes ☐ No

Are any of your teeth sensitive to heat, cold, chewing or sweets? ☐ Yes ☐ No

Have you ever been treated for pain in the jaw joints? ☐ Yes ☐ No

Are you apprehensive about dental treatment? ☐ Yes ☐ No

Have you ever received orthodontic treatment? ☐ Yes ☐ No

If so, when? _____

Did you wear or do you currently wear retainers? ☐ Yes ☐ No

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Signature: _____ Date: _____

INFORMED CONSENT TO PHOTOGRAPH

Date: _____

I, _____, due hereby give consent for Dr. Sedaghatfar
(Legal Guardian)

to take and/or display photograph(s) of the face, teeth and gums of

_____. Photographs will be used for treatment
(Patient's Name)

purposes by Dr. Sedaghatfar and/or used during treatment discussions

with your general dentist or other necessary healthcare providers, including insurance.

Print Name: _____ Signature: _____

Relation to Patient:

___ Self ___ Guardian Witness

Dr. Michael Seda Office Policy Agreement

48 Hour Cancellation Policy

Cancellation and late arrival phone number: (415) 482-9901

Please store this number where it will be convenient for you if you need it

You will never be charged for a cancellation if it is made more than 48 hours in advance of your scheduled appointment time.

Reason for this policy: Notifying us of your intention to cancel or reschedule 48 in advance gives us an opportunity to schedule someone else for that time slot. This is important because others may be on a waiting list or may also be looking for an opportunity to reschedule for a different time. As much advance notice as possible is always appreciated. Patients are here to address urgent needs and our ability to provide openings is crucial to the well being and immediate health of our patients.

IF YOU CANCEL YOUR APPOINTMENT WITH LESS THAN 48 HOURS NOTICE OR DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT, YOU WILL BE CHARGED \$75 FOR THE MISSED APPOINTMENT

Because it is illegal to bill your insurance company for a missed appointment, you will end up paying the fee for the missed session out-of-pocket.

This cancellation policy is standard in the medical and dental health fields and will be strictly enforced.

On occasion, there will be understandable reasons for missing appointments, but exceptions to this policy will be rare.

Arriving late with notification: If you notify our office, even a few minutes ahead of time by calling the number above, your appointment time will be held for you and you will have the time which remains in that appointment.

If you arrive late without notification, we will wait for you for 7 minutes, after which we will assume you are not coming and may leave the office or treat the next patient. In such case, you will be charged for your missed appointment and give you the opportunity to reschedule your missed appointment.

If you have questions about this cancellation policy, you should discuss this with us before signing this form.

The underlying reasoning behind this policy is so that we can best serve you and all of our patients.

Please sign below to indicate you have read, understand, and agree to abide by our cancellation policy.

Thank you.

Print Name

Date

Signature

Explaining Your Insurance Coverage In Our Office

In order to serve you best, we want to be as clear as possible about how insurance coverage works for periodontal treatment in our office. The following explains the methods we employ to have your insurance estimate be as accurate as possible in addition to assisting you in getting your insurance to cover as much of your procedures as possible. Despite all of our efforts, sometimes insurance companies may still reserve the right to cover less of a procedure or no part of a procedure. Please see below for an explanation of how we handle insurance coverage in our office:

1) Upon your consultation visit, a treatment plan is determined. If the treatment plan involves any periodontal treatment, a predetermination can and may be sent to the insurance company the same day as your consultation visit. Predeterminations can take anywhere from 2 weeks to 6 weeks to be answered by the insurance company. When the predetermination is received, it will clearly state the amount of coverage to be provided by your insurance company for the procedure submitted for future treatment. As long as you have not undergone any further dental treatment with any dentist for which your insurance would have been billed since the day of your consultation, your insurance should pay the stated amount on the predetermination form for the periodontal treatment submitted. In addition to our office receiving a copy of the predetermination form, you should also receive a copy from your insurance company.

2) In addition to sending a formal predetermination, we recommend that you call your insurance company to obtain an "over the phone" estimate. This allows you to understand your benefits better and be empowered in the process. We also find that the information provided to subscribers is more accurate than the information provided to us as specialist providers. The information you receive from the insurance company typically results in a fairly accurate estimate of coverage for your periodontal treatment, however, there have been instances where the information given over the phone is inaccurate and actual coverage of the periodontal treatment differs greatly. This is why we typically send a formal predetermination as stated above. It is your decision if you want to schedule treatment prior to receipt of the predetermination form and rely on the "over the phone" estimate. We recommend that if you have any concerns whatsoever about the amount of insurance coverage that you rely on the predetermination form only. As is true for the predetermination coverage, any information that you obtain over the phone regarding an insurance coverage estimate only applies if you have received no additional dental treatment with any dentist since the time of the "over the phone" estimate.

3) Lastly, despite the above explained methods, insurance companies may still make errors regarding predeterminations and "over the phone" estimates. These are evident when the insurance coverage check is received in our office (or by you) and the amount paid is less than expected or completely denied. Although this happens very rarely with formal predeterminations, we want you to know that it is a possibility. Should this occur, we will work with you and your insurance company to the best of our ability to get you the coverage that is reasonable. This may involve us writing a letter to insurance companies, sending photos or charting, or even having you call on your own behalf as a consumer. **However, any balance after the procedure has been completed, insurance submitted, and an explanation of benefits received, is considered your responsibility despite any misinformation given by the insurance company.**

We hope this clearly outlines the insurance process. We want you to be an empowered, informed patient. Please do not hesitate to contact us with any questions you may have. We want to ensure that you come and go from our office with a smile on your face and with confidence in us as practitioners and as your liaisons to the insurance world.

I, [REDACTED] have been informed of the insurance process in Dr. Sedaghatfar's office as outlined above and have had the opportunity to ask any relevant questions. Therefore, I hereby state that I understand the insurance process in Drs. Sedaghatfar and Brinker's office, as outlined above.

Date: [REDACTED]

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: Test Test

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Michael Sedaghatfar Address: 711 D Street, Suite 107, San Rafael, CA 94901

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, [REDACTED], have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, [REDACTED], have received a copy of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: ☐ Individual Refused to Sign ☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify: _____)

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.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about your 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 health information to a physician or other health provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your 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 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 health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the “Patient Rights” section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment to your 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 of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstance, 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 healthcare. We will also use our professional judgment and our experience with common practice 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 if health information.

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

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your 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 national security services. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your 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 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 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 \$1.00 for each page, \$20 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 health information in that format. If you prefer, we will prepare a summary or an explanation of your 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 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 restrictions on our use or disclosure of your 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 health information by alternative means or to alternate locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handles under the alternative means or location you request.

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.

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 privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or discloser of your health information or the 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 privacy of your health information. We will 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 Officer:
Michael Sedaghatfar, D.M.D
711 D Street, Suite 107
San Rafael, CA 94901
415-482-9901 Phone/ 415-482-9902 Fax