REGISTRATION

Today's Date _____

PATIENT'S INFORMATION

Name:			DOB:	SS#:
Address:				
City:	State:	Zip:		Driver's Lic.#:
Home Phone:	Work Phone:			Cell Phone:
E-mail:				
Preferred method of contact:	Phone	Text	Email	Other:

INSURANCE –DENTAL

Policy Holder Name:	DOB:	SS#:
Employer:	Group #:	ID#
Dental Ins. Co. Name:	Ins. Co. Phone #:	
Claim Mailing Address:		

INSURANCE –MEDICAL

Policy Holder Name:	DOB:	SS#:
Employer:	Group #:	ID#
Dental Ins. Co. Name:	Ins. Co. Phone #:	
Claim Mailing Address:		

Please be advised that our office is OUT-OF-NETWORK with all insurance companies. Dr. Kacher does not participate in any PPO, DMO or HMO plans. Therefore, any benefits used in our office will be considered out-of-network with your insurance company.

As a courtesy to you, our office will bill your insurance carrier. We will collect an estimated co-payment from you on the day of your treatment. In any event that your insurance company does not pay for the balance of procedures performed, you are ultimately responsible for your account balance within 60 days from any treatment.

FINANCIAL RESPONSIBILITY

Name:
Address:
Phone:

May we contact your previous dentist or specialist for information? YES NO

*Who may we thank for inviting you to our office?*_____

_____ _____

PATIENT SIGNATURE **DATE**

PATHOLOGY

ORAL MEDICINE CONFIDENTIAL HEALTH HISTORY

PATIENT NAME:	**DATE:**
Referring Doctor:	
Reason for referral:	

Are you currently under the care of a physician? YES NO If yes, why?

MEDICAL HISTORY – *PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE*:

DIABETES	RASH OR SKIN TROUBLE	SHORTNESS OF BREATH	JOINT REPLACEMENT
HEART TROUBLE	VISION PROBLEMS	ASTHMA	BLOOD TRANSFUSION
LIVER CONDITION	HEARING PROBLEMS	TUBERCULOSIS	FREQUENT HEADACHES
CANCER/TUMOR	BLOOD DISORDER	BACK PROBLEMS	DIZZINESS
HEPATITIS	JAUNDICE	HIV/AIDS	KIDNEY TROUBLE
CHEMOTHERAPY	HIGH BLOOD PRESSURE	BLOOD DISORDER	EPILEPSY
ARTHRITIS/GOUT	RHEUMATIC FEVER	LUNG CONDITION	BLEEDING PROBLEMS

Are you allergic to any food or medications? YES NO If yes, please list name and reaction:

Do you need antibiotic pre-medication prior to dental treatment? YES NO

Have you been hospitalized in the past 3 years? YES NO If yes, explain:

MEDICATIONS CURRENTLY TAKING:

Medication Name	Dose	Frequency	Date Started	Reason for taking

Do you regularly use cinnamon-containing chewing gum or candy? YES NO
Do you use any herbal medications or supplements? YES NO

Tobacco use? YES NO	*Smoke*: Pipe	Cigar	Cigarettes	Frequency:
	Smokeless: Type:			Frequency:
Alcohol use? YES NO	*Amount*: Minimal	Moderate	Heavy	

Women: Are you pregnant? YES NO	Are you nursing: YES NO

PATIENT SIGNATURE_____ **DATE:**_____

PATHOLOGY

Oral Medicine ● Oral Pathology

Clinical Patient Authorization

I consent to having a clinical oral medicine exam by Dr. John Kacher for the purpose of diagnosing my oral condition. I authorize the release of my medical or other information necessary to process my insurance claim or in communication as deemed necessary with the referring doctor or consulting doctors.

We will file an insurance claim for this service with my medical insurance carrier. The rate of insurance coverage varies by plan, deductible, spending limits, and other factors that are part of my insurance plan.

As such, I am financially responsible for the balance on my account with Dr. Kacher and will be billed directly for this balance. All patients are responsible for payment regardless of insurance coverage. **We are not providers of any State Benefit Programs or for Medicare. They do not cover our services. Claims for Medicare beneficiaries will be submitted for secondary insurance coverage, if available.**

Please indicate your understanding of this policy by signing and dating below.

I have read and understand the above and consent to microscopic tissue evaluation of this biopsy specimen.

_____

Patient name or Legal Guardian Date

_____

Patient Signature

JKJ Pathology 4223 Research Forest Dr., Ste 500 The Woodlands, TX 77381
johnkacher@jkjpathology.com www.jkjpathology.com
(T) 281-292-7954 (F) 281-292-7372

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

JKJ Pathology

✧ You May Refuse to Sign This Acknowledgment ✧

I, _____, have reviewed/received a copy of this office's Notice of Privacy Practices.
(*print PATIENT name)*

_____
Please Print PATIENT Name

_____
Signature of Patient or Guardian ***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 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 our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect (04/14/03) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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 health information to a physician or other healthcare 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 Patients 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 for 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 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 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 of 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 activities. 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 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 requests, 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 alternative 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 handled under the alternative means of 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 access to your health information or in response to a request you made to amend or restrict the use of disclosure of your 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 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 the privacy of your 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 Officer: Dr. John Kacher Telephone: 281-292-7954 Fax: 832-442-3373 E-mail: johnkacher@jkjpathology.com

Address: 4223 Research Forest Dr., Ste. 500 The Woodlands, TX 77381