East Taylor Dental Associates
family, cosmetic & implant dentistry

Welcome to our practice! We are dedicated to performing high quality dental care using the latest dental technology advancements in a caring and friendly environment; providing our patients with a uniquely positive dental experience. We thank you for choosing to be a part of our dental practice and welcome your referrals of family and friends.

지희 치과에 오신것을 환영합니다. 저희는 친절함과 최신 치과기술로 특별한 치료환경을 제공하기 위하여 최선을 다하고 있습니다. 가족이나 지인의 추천도 환영합니다.

Please complete all attached paperwork prior to your visit, paying careful attention to sign where required. You may bring it with you to your appointment, fax to (334)271-4709, or email to registration@easttaylordental.com. If you have any questions about the policies included, please do not hesitate to ask.

최상의 치료를 위하여 다음의 모든 서류를 검토 및 답변 부탁드립니다. 모든 페이지를 검토 후, 서명이 필요한 페이지에 반드시 서명 부탁드립니다. 작성 후, 진료하는 날 직접 가져오시거나, 미리 334-271-4709 로 팩스로 보내주시거나, registration@easttaylordental.com 으로 이메일 부탁드립니다.

Please bring this completed packet of paperwork as well as your valid photo identification and insurance cards to your appointment.

모든 서류와 신분증, 그리고 보험증을 지참해주시기 바랍니다.

East Taylor Dental, PC
2201 Taylor Road
Montgomery, AL 36117
www.easttaylordental.com
(334)271.4600 Phone (334)271.4709 Fax

EAST TAYLOR DENTAL, PC - PATIENT REGISTRATION INFORMATION

ID: _____ Salutation: ☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr.

First Name_____ Last Name _____Middle Initial ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (If someone other than patient)

First Name: _____Last Name: _____Middle Initial ____

Address: _____Address 2: _____

City, State, Zip _____

Home Phone: _____Work Phone: _____ Ext _____ Cell: _____

Birthdate: _____Soc Sec #: _____Drivers Lic # _____

Employer: _____ Employer Phone: _____

☐ Responsible Party is also an Insurance policy holder for patient ☐ Primary Insurance ☐ Secondary Insurance

Patient Information

Address: _____ Address 2: _____ _____

City, State, Zip _____

Home Phone: _____Work Phone: _____ Ext _____ Cell: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birthdate: _____Age _____Social Security #: _____/____/_____ Drivers Lic #_____

E-mail: _____ ☐ I would like to receive correspondence by: ☐ E-mail ☐ Text

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Applicable

Employer Name: _____ Employer Phone: _____

Address: _____City, State, Zip _____

Student Status: ☐ Full Time ☐ Part Time Name of School: _____

Address: _____City, State, Zip _____

Preferred Pharmacy: _____Location/Address: _____

ER Contact: _____ER Phone: _____Your Best # from 8 am-5pm_____

Spouse Information

First Name: _____ Last Name _____Middle Initial_____

Address: _____ City, State, Zip _____

Home Phone: _____Work Phone:_____Ext____ Cell:_____Social Security____/___/_____

Employer: _____ Employer Phone: _____ Sex: ☐ Male ☐ Female

EAST TAYLOR DENTAL, PC - INSURANCE REGISTRATION

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Social Security #_____/_____/_____ Insured's Date of Birth: _____/_____/_____

Employer: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Insurance Company: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Subscriber/Contract Number: Group Number:

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Social Security #_____/_____/_____ Insured's Date of Birth: _____/_____/_____

Employer: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Insurance Company: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Subscriber/Contract Number: _____ Group Number: _____

PRIMARY MEDICAL INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Social Security #_____/_____/_____ Insured's Date of Birth: _____/_____/_____

Employer: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Insurance Company: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Subscriber/Contract Number: _____ Group Number: _____

SECONDARY MEDICAL INSURANCE INFORMATION: (Abbreviated)

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Social Security # _____/_____/_____ Insured's Date of Birth: _____/_____/_____

Employer: _____ Telephone: _____ Address: _____

Insurance Company: _____ Telephone: _____ Address: _____

Subscriber/Contract Number: _____ Group #: _____ Do companies coordinate benefits? ☐ Yes ☐ No

East Taylor Dental, P.C.
Medical History

Patient Name: _____

Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.
현재의 건강 상태나 복용중인 약이 치과치료와 중요한 상호 관계를 가질 수 있으므로 다음 질문에 답변 부탁드립니다. 감사합니다.

☐ YES ☐ NO Are you under a physician's care now?
현재 의사의 관리하에 있습니까? _____

☐ YES ☐ NO Have you ever been hospitalized or had a major operation?
당신은 병원에 입원 또는 수술을 받은적이 있습니까? _____

☐ YES ☐ NO Have you ever had a serious head or neck injury?
심각한 머리와 목 부상을 입었던 적이 있습니까? _____

☐ YES ☐ NO Are you taking any medications, pills, or drugs?
당신은 **현재** 복용하고 있는 약이 있습니까? _____

➢ **Please Complete Medications List** 약물 목록을 작성하십시오

☐ YES ☐ NO Do you take, or have you taken, Phen-Fen or Redux?
Phen-Fen 이나 Redux 를 복용한적이 있습니까?

☐ YES ☐ NO Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Fosamax, Boniva, Actonel 등 비스포스포네이트를 포함하는 약물을 복용한적이 있습니까?
_____

☐ YES ☐ NO Are you on a special diet?
채식주의등의 특별한 식단이 있습니까 ? _____

☐ YES ☐ NO Do you use tobacco?
흡연하십니까? _____

☐ YES ☐ NO Do you use controlled substances?
진통제등 규제 약물을 복용하고 있습니까? _____

Women: Are you...
여성 :

☐ Pregnant/ Trying to get pregnant?
임신 중이거나 임신계획중 이십니까?

☐ Nursing
모유수유중

☐ Taking oral contraceptives?
경구 피임약 복용

Are you allergic to any of the following?
당신은 다음 중 하나에 알레르기가 있습니까?

☐ Aspirin
아스피린

☐ Penicillin
페니실린

☐ Codeine
코데인

☐ Acrylic
아크릴

☐ Metal
금속

☐ Latex
라텍스

☐ Sulfa Drugs
외상 치료 약물

☐ Local Anesthetics
국소 마취제

☐ Other Allergies?
다른 알레르기? _____

Do you have, or have you had any of the following? 다음의 질환을 앓고 있거나 앓은적이 있습니까?

- ◯ Yes ◯ No AIDS/HIV Positive 에이즈
- ◯ Yes ◯ No Alzheimer's Disease 치매
- ◯ Yes ◯ No Anaphylaxis 아나필락시스 (과민증)
- ◯ Yes ◯ No Anemia 빈혈
- ◯ Yes ◯ No Angina 협심증
- ◯ Yes ◯ No Arthritis/Gout 관절염 / 통풍
- ◯ Yes ◯ No Artificial Heart Valve 인공관절
- ◯ Yes ◯ No Artificial Joint 인공관절
- ◯ Yes ◯ No Asthma 천식
- ◯ Yes ◯ No Blood Disease 혈액질환
- ◯ Yes ◯ No Blood Transfusion 수혈
- ◯ Yes ◯ No Breathing Problems 호흡곤란
- ◯ Yes ◯ No Bruise Easily 쉽게 멍이 듬
- ◯ Yes ◯ No Cancer 암
- ◯ Yes ◯ No Chemotherapy 항암 화학요법
- ◯ Yes ◯ No Chest Pains 가슴통증
- ◯ Yes ◯ No Cold Sores/Fever Blisters 입술포진
- ◯ Yes ◯ No Congenital Heart Disorder 선천성 심장병
- ◯ Yes ◯ No Convulsions 발작
- ◯ Yes ◯ No Yellow Jaundice 황달
- ◯ Yes ◯ No Hemophilia 혈우병
- ◯ Yes ◯ No Hepatitis A A형 간염
- ◯ Yes ◯ No Hepatitis B or C B형, C형 간염
- ◯ Yes ◯ No Herpes 헤르페스
- ◯ Yes ◯ No High Blood Pressure 고혈압
- ◯ Yes ◯ No High Cholesterol 고지혈증
- ◯ Yes ◯ No Hives or Rash 두드러기
- ◯ Yes ◯ No Hypoglycemia 저혈당증
- ◯ Yes ◯ No Irregular Heartbeat 불규칙적인 심장박동
- ◯ Yes ◯ No Kidney Problems 신장 질환
- ◯ Yes ◯ No Leukemia 백혈병
- ◯ Yes ◯ No Liver Disease 간질환
- ◯ Yes ◯ No Low Blood Pressure 저혈압
- ◯ Yes ◯ No Lung Disease 폐질환
- ◯ Yes ◯ No Mitral Valve Prolapse 승모판 탈출증
- ◯ Yes ◯ No Osteoporosis 골다공증
- ◯ Yes ◯ No Pain in Jaw Joints 악골(턱)의 통증
- ◯ Yes ◯ No Parathyroid Disease 부갑상선 질환
- ◯ Yes ◯ No Psychiatric Care 정신질환
- ◯ Yes ◯ No Sleep Apnea 수면 무호흡증
- ◯ Yes ◯ No Cortisone Medicine 코르티손 약물
- ◯ Yes ◯ No Diabetes 당뇨
- ◯ Yes ◯ No Drug Addiction 약물 중독
- ◯ Yes ◯ No Easily Winded 쉽게 숨이 참
- ◯ Yes ◯ No Emphysema 폐기종
- ◯ Yes ◯ No Epilepsy or Seizures 간질
- ◯ Yes ◯ No Excessive Bleeding 심한 출혈
- ◯ Yes ◯ No Excessive Thirst 심한 갈증
- ◯ Yes ◯ No Fainting Spells/Dizziness 어지럼증
- ◯ Yes ◯ No Frequent Cough 잦은 기침
- ◯ Yes ◯ No Frequent Diarrhea 잦은 설사
- ◯ Yes ◯ No Frequent Headaches 잦은 두통
- ◯ Yes ◯ No Genital Herpes 음부포진
- ◯ Yes ◯ No Glaucoma 녹내장
- ◯ Yes ◯ No Hay Fever 고초열 (알레르기성 비염)
- ◯ Yes ◯ No Heart Attack/Failure 심장마비 / 심근경색
- ◯ Yes ◯ No Heart Murmur 심잡음
- ◯ Yes ◯ No Heart Pacemaker 심장 페이스메이커
- ◯ Yes ◯ No Heart Trouble/Disease 심장질환
- ◯ Yes ◯ No Snoring 코골이
- ◯ Yes ◯ No Radiation Treatments 방사선 치료
- ◯ Yes ◯ No Recent Weight Loss 최근의 몸무게 감소
- ◯ Yes ◯ No Renal Dialysis 인공투석
- ◯ Yes ◯ No Rheumatic Fever 류마티스성 열
- ◯ Yes ◯ No Rheumatism 류마티스
- ◯ Yes ◯ No Scarlet Fever 성홍열
- ◯ Yes ◯ No Shingles 대상포진
- ◯ Yes ◯ No Sickle Cell Disease 겸상 적혈구 빈혈
- ◯ Yes ◯ No Sinus Trouble 축농증
- ◯ Yes ◯ No Spina Bifida 척추뼈 갈림증
- ◯ Yes ◯ No Stomach/Intestinal Disease 위장 질환
- ◯ Yes ◯ No Stroke 뇌졸중
- ◯ Yes ◯ No Swelling of Limbs 팔다리가 붓는 증상
- ◯ Yes ◯ No Thyroid Disease 갑상선 질환
- ◯ Yes ◯ No Tonsillitis 편도선염
- ◯ Yes ◯ No Tuberculosis 폐결핵
- ◯ Yes ◯ No Tumors or Growths 종양
- ◯ Yes ◯ No Ulcers 궤양
- ◯ Yes ◯ No Venereal Disease 성병
- ◯ Yes ◯ No Other, Please List. 기타

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform he dental office of any changes in medical status.

★ ***Signature of Patient, Parent or Guardian:*** (환자나 보호자 서명) ***Date:*** (날짜)

_____ _____

EAST TAYLOR DENTAL, P.C. – PATIENT MEDICATION LIST

PATIENT NAME: _____ **ACCT #**_____ **DATE:** _____

Prescription Medications (Include Vitamins, Herbs & Over the Counter Medications)	**Prescribed Dosage**	**Frequency & When Taken** (AM/Noon/PM)	**Name of Prescribing Doctor**	**Condition or Reason for taking Medication**	**For Office Use Only**
Ex: Nexium	40mg	One dose per day @ bedtime	Dr. Feel Good	Peptic Ulcer	

To the best of my knowledge, the above listed medications etc. are accurate for this patient. I understand that providing incorrect information can be dangerous to this patient's health. Signature of Patient or Parent of Patient: _____

(If medications extend beyond this page, please complete a second form)

EAST TAYLOR DENTAL, P.C.
DENTAL HISTORY

Patient Name	
Date of Birth	Medical Alert

Welcome! *So that we may provide you with the best possible care please complete both sides of this form. It is important that we know about your Medical and Dental History. These facts have a bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank You for taking the time to completely fill out this questionnaire!*
저희 치과에 찾아주셔서 감사합니다. 저희가 환자분의 건강상태나 그동안의 치과치료 내에 대해 아는것이 최선의 치료를 제공하는데 중요한 역할을 합니다. 여기에 작성하시는 모든 내용은 환자분 이외의 누구에게도 제공되지 않습니다. 설문 작성에 시간을 내어주셔서 미리 감사합니다.

What is the reason for your visit today? 오늘 치과를 방문한 목적은 무엇입니까?_____

Date of Last Dental Visit 마지막 치과 방문의 날짜_____ (월, 년도) ***Last Cleaning*** 마지막 스케일링 날짜_____ (월, 년도)

What was done on your last dental visit? 마지막으로 치과방문시 치료 내용_____

Previous Dentist's Name 이전 치과 의사의 이름_____ ***Telephone*** 전화번호_____

How often do you have dental examinations? 얼마나 자주 치과 검진을 받으십니까?_____

How often do you brush your teeth? 얼마나 자주 양치를 하십니까?_____

How often do you floss? 얼마나 자주 치실을 사용하십니까?_____

What other dental aids do you use? (Interplak, toothpick, etc.) 다른 관리 도구를 사용하십니까?
(이쑤시개, 치간칫솔 등)_____

Do you have any dental problems now? 지금 치아에 문제가 있으십니까?
(If yes, please describe): (그렇다면, 설명)_____

Are any of your teeth sensitive to: 다음에 통증이 있으십니까?

Hot or cold? (뜨겁거나 찬 음식)	Yes	No
Sweets? (단것)	Yes	No
Biting or Chewing? (씹을때나 다물때)	Yes	No
Have you noticed any mouth odors or bad tastes? (입냄새가 나거나 쓴맛을 느끼십니까?)	Yes	No
Do you frequently get cold sores, blisters, or any other oral lesions? (입바늘이나 혓바늘 또는 물집이 자주 생기십니까?)	Yes	No

Have you ever had:

Orthodontic treatment? (교정을 해본적이 있나요?)	Yes	No
Oral Surgery? (사랑니 발치등 구강외과 치료를 받은적이 있습니까?)	Yes	No
Periodontal treatment? (치주염 치료를 받은적이 있습니까?)	Yes	No
Your teeth ground or bite adjusted? (교합을 교정받거나 씹는면을 교정받은적이 있습니까?)	Yes	No
A bite plate or mouth guard? (마우스피스를 사용한적이 있습니까?)	Yes	No

Do your gums bleed or hurt? *Yes* *No*
잇몸에서 피가나거나 통증이 있습니까?

Have your parents experienced gum disease or tooth loss? *Yes* *No*
치주염을 앓거나 이빨이 빠진적이 있습니까?

Have you noticed any loose teeth or change in your bite? *Yes* *No*
흔들리는 이가 있거나, 다물때 전과 다른 변화가 있습니까?

Does food tend to become caught in your teeth? *Yes* *No*
음식이 이사이에 잘 끼나요?

Are you satisfied with the appearance of your teeth? *Yes* *No*
현재 치아에 만족하십니까? (모양, 색깔, 교합 등)

Do you:

Clench or grind your teeth while awake or Asleep? *Yes* *No*
이를 갈거나 이악물기를 하시나요?

Bite your lips or cheeks regularly? *Yes* *No*
입술이나 볼을 자주 깨무시나요?

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) *Yes* *No*
연필, 손톱등을 깨무는 버릇이 있습니까?

Mouth breathe while awake or asleep? *Yes* *No*
주무시거나 평소에 입으로 호흡을 하십니까?

Have tired jaws, especially in the morning? *Yes* *No*
아침에 턱관절이 아프십니까?

Smoke or chew tobacco? *Yes* *No*
흡연하십니까?

Have frequent heavy snoring? *Yes* *No*
자주 심한 코골이를 하십니까?

Which effects the sleep of others? *Yes* *No*
코골이가 다른 사람의 수면을 방해합니까?

Have significant daytime drowsiness? *Yes* *No*
기면증세나 혼곤증이 잦습니까?

Have night time choking spells? *Yes* *No*
수면중 호흡정지가 있을때가 있습니까?

Been told that "I stop breathing" when Sleeping? *Yes* *No*
수면시 호흡정지가 있다는 말을 들은적이 있습니까?

Have you experienced:

Clicking or popping of the jaw? *Yes* *No*
턱관절의 클릭이 있거나 관절빠짐이 있던적이 있습니까?

Pain? (joint, ear, side of face) *Yes* *No*
턱관절, 귀, 얼굴 측면의 통증을 느낀적이 있습니까?

Difficulty opening or closing your mouth? *Yes* *No*
개구가 힘드십니까?

Difficulty chewing on either side? *Yes* *No*
어느 한쪽 씹는것이 불편한 적이 있습니까?

A serious injury to the mouth or head? *Yes* *No*
If so, please describe, including cause
머리나 입주변의 심한 외상을 입은적이 있습니까?
있다면 설명; _____

Would you like to keep your teeth all of your life? *Yes* *No*
본인 치아를 평생 사용하고 싶으십니까?

Do you feel nervous about having dental treatment? *Yes* *No*
치과치료에 대한 두려움이 있습니까?

If so, what is your biggest concern?
있다면 걱정되는 부분은 무엇입니까?

_____

_____

Have you ever had an upsetting dental experience? *Yes* *No*
좋지않은 치료경험이 있으십니까?
If yes, please describe

_____

_____

_____

Is there anything else about having dental treatment that you would like us to know?

치과치료에 대한 다른 걱정이나 저희가 알아야 할 사항이 있으십니까?

_____

_____

_____

EAST TAYLOR DENTAL, PC
KILLIAN J. HORNER, DDS
JENNIFER D. AHN, DMD
2201 Taylor Road
Montgomery, Alabama 36117
Telephone: (334) 271-4600 Fax: (334) 271-4709

INFORMED CONSENT FOR TREATMENT
치료에 대한 동의

- *I hereby authorize the dentist to designate staff to take x-rays, study models, photograph's and any other diagnostic aids deemed appropriate by the dentist to make a through diagnosis of myself or my dependents dental needs. Upon such diagnosis, I understand a treatment plan will be formulated. From this treatment plan, I will be provided with an estimate of the cost of the treatment. However, I understand that this is only an ESTIMATE.*
  본인은 자신 또는 부양 가족 치과 치료 진단을 위해 의사가 직원에게 지정하는 모든 엑스레이나, 사진, 연구 모델 및 다른 진단을 위한 보조도구를 승인합니다.
  이러한 자료들을 바탕으로 진단된 후 치료에 대한 전체적인 계획이 이루어질것을 이해합니다. 그 치료계획에서 대략적인 견적서가 제공될 것이며 이는 추정적 견적서일 뿐 임을 이해합니다.

- *I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.*
  본인은 의사가 추천하는 적절한 치료를 상호 합의하에 제공하는 데 필요한 모든 자료나 보조도구를 승인합니다.

- *I also understand that, during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those originally planned. I therefore authorize and request that the doctors and staff of East Taylor Dental Associates perform such procedures as are necessary and desirable in the exercise of sound professional judgment.*
  본인은 치료 과정에서 예상치 못한 치아 상태나 질환이 발생하여 원래 계획과는 다른 절차들이 필요될 수 있다는 것을 이해한다. 그래서 나는 East Taylor Dental Associates의 의사들이나 스탭들에게 전문적인 판단에 의해 필요하고 바람직하다고 생각되는 과정이나 치료를 승인합니다.

- *I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications. Possible complications in general dentistry includes, but are not limited to:*
  본인은 어떤 치과 치료도 위험부담이 완전히 없지는 않다는것을 이해하고, 치과 의사가 합병증을 예방하기 위해 합리적인 조치를 취할 것을 이해합니다. 일반적인 치과 치료에서 생길수 있는 위험부담이나 합병증 :

  1) *Post-operative discomfort and swelling which may necessitate several days of home recuperation.*
     며칠간 휴식을 필요로 하는 수술 후 불편함과 붓기

  2) *Injury to adjacent teeth and fillings.*
     인접한 치아나 인접치아의 치료부분 (레진이나 아말감등)의 손상

  3) *Post-operative infection requiring additional treatment.*
     추가 치료를 필요로하는 수술 후 감염.

  4) *Stretching of the corners of the mouth with resultant cracking and bruising.*
     양쪽 입꼬리의 찢어짐이나 멍

  5) *Restricted mouth opening for several days or weeks.*
     몇 일 또는 몇 주 동안 지속되는 입벌림 제한

  6) *Injury to the nerve underlying the teeth during anesthesia (shots) or extractions resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this may persist for several weeks,*

months or in rare instances, permanently.
마취나 발치중 발생될 수 있는 턱, 입술, 볼, 잇몸이나 혀등의 기초신경 손상 또는 마비; 이는 몇주나 몇달동안 지속될 수 있으며 아주 드문경우에는 영원히 마비되는 경우도 생길 수 있습니다.

7) *Discoloration at the injection site or in rare cases, bruising of the cheek close to the injection site.*
주사부위의 탈색 또는 아주 드물게는 마취주사쪽의 볼에 멍이 드는 경우

8) *Exposure of the nerve while preparing the tooth for a filling or crown.*
충치치료나 크라운치료 중 치아 신경의 노출

9) *The need for root canal therapy after restorative work (e.g. fillings, crown) resulting from deep restorations or stress caused by multiple restorations to the same tooth.*
충치치료나 크라운치료등의 보철치료후 필요화 될 수 있는 신경치료의 가능성

❖ *I agree to the use of anesthetics, sedative and other medications as necessary.*
본인은 필요에 따라 마취제, 진정제 등의 약물 사용에 동의합니다.

❖ *I understand that it is important for me to understand the treatment being rendered, pros and cons of that treatment, and any possible alternative treatments.*
본인은 각 치료의 장점과 단점 및 가능한 대안 치료를 이해하는 것이 중요하다고 이해합니다.

❖ *I understand that if I do not understand the proposed treatment, it is better to ask any questions I have before treatment is started.*
본인이 제안된 치료를 이해하지 못하는 경우, 치료를 시작하기 전에 질문을 하는것이 더 좋다는 것을 이해합니다.

PHOTO RELEASE
사진 사용

❖ *The Doctors and the staff of East Taylor Dental, P.C. may periodically request to take photographs, slides, and/ or videos of your face, jaws and teeth. The photographs, slides, and or videos will be used as a record of your care, and may be used for educational and marketing purposes in lectures, demonstrations, and professional publications including our avenues of social media and website.*
저희 치과의 의사들이나 스태프들이 환자분의 얼굴, 상악과 하악, 그리고 치아의 사진이나 동영상을 찍게 되는 경우가 있을 수 있습니다. 이러한 사진이나 슬라이드, 또는 동영상은 환자분의 치료 자료뿐 아니라 교육이나 마케팅용으로 연구자료, 논문, 인터넷 website 나 소셜미디어등에 사용될 수 있습니다.

Please check one of the following: 다음에서 원하시는 부분에 체크하여 주십시오.

☐ **I consent to all photographs (full face included)**
전체 얼굴 사진을 포함한 모든 사진의 사용을 허용함.

☐ **I consent to "teeth only" photographs**
치아 사진만의 사용을 허용함.

☐ **I consent to photographs for record of my care, but <u>do not</u> release any photos for marketing purposes.**
치료의 기록을 위한 사진의 촬영은 허락하나, 마케팅을 위한 사진의 사용은 금지함.

❖ *I further understand that if the photographs, slides, and/or videos are used in any publication, or as part of a demonstration, or on our website, reasonable attempts will be made to conceal my identity (i.e. no name or other identifying info will be given, full face photos excluded).*

만약 치과에서 촬영된 사진이나 동영상이 사용될 경우, 본인의 신원보호를 위한 적절한 노력이 이루어 질 것을 이해합니다. (성함등 신원이 공개될만한 정보는 공개되지 않을것이나, 전체 얼굴 사진은 제외됩니다.)

INFORMED CONSENT FOR TREATMENT
치료에 대한 동의

PATIENT NAME ***-please print***

환자 이름: _____

PATIENT, PARENT, OR GUARDIAN SIGNATURE:

환자, 부모, 또는 보호자 서명 : _____

DATE:

날짜: _____

I, the undersigned patient and/or guarantor, understand and accept that East Taylor Dental has provided the translation of their written policies and procedures, (to the best of their knowledge), into Korean as a courtesy to me. I also fully understand and accept that the English version of East Taylor Dental's written policies and procedures are their standard legal version.
본인은 (또는 법적 보호자) East Taylor 치과에서 모든 정책이나 절차에 관해 최선을 다해 번역 서비스를 제공했음을 이해합니다. 하지만, 모든 문서는 영어로 된 버전이 법적 효용성을 갖는다는것을 이해하고 동의하여 받아들입니다.

SIGNATURE 서명 _____ **DATE** 날짜 _____

EAST TAYLOR DENTAL, PC
KILLIAN J. HORNER, DDS
JENNIFER D. AHN, DMD
2201 Taylor Road
Montgomery, Alabama 36117
Telephone: (334) 271-4600 Fax: (334) 271-4709

OFFICE POLICIES
병원 정책

We are concerned about the cost of your dental care and want to address some current issues related to the cost of dental services. Considerable care has been taken in setting our fees. Every effort has been made to insure that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Please take a moment to review our policies. Please ask all questions before signing. Thank you.

저희는 치과 치료 비용에 대한 환자분의 우려 및 현재 미국에서의 치과치료 가격에 대한 문제를 이해하는바, 치료의 복잡성과 전문 기술 또는 지식을 필요로 함을 반영하여 치료가격을 책정하였습니다. 다음의 저희 병원 정책을 검토하신후 질문이 있으시면 서명하시기 전에 질문해 주십시오. 감사합니다.

APPOINTMENTS
예약

- Once an appointment is made, please remember this time is reserved specifically for you.
  치료 예약이 되면 그 시간이 환자분을 위해 예약된다는것을 기억하여 주십시오.

- If you must change your appointment time, East Taylor Dental Associates requires a forty-eight (48) hour, (at least 2 full business days) notice on any cancellation or re-scheduled appointment. (Legitimate emergencies are an exception.)
- 치료예약 시간을 변경하셔야 할 경우, 48 시간 이전(병원영원 시간내)에 연락을 주시기 바랍니다. (응급상황 예외)

- We reserve the right to assess a fee for the time reserved for an appointment in which a 2 business day's cancellation notice is not given, as stated above. This fee can range from a minimum of $25.00 to $125.00/half hour, based on the complexity of services to be performed at your time of visit.
  저희는 위에서 언급한 바와같은 예약취소가 되지 않았을경우 벌칙금을 요구할 권리를 보유합니다. 이 비용은 치료의 복잡성이나 예약된 시간에 따라, 30 분당 $ 25.00 에서 $125.00 까지 될 수 있습니다.

- Cancellation or appointment changes must be handled by a staff member and not via our voicemail system.
  취소 또는 예약 변경은 음성메일이 아닌 직원에 의해 처리가 되어야합니다.

INSURANCE
보험

- If you have dental insurance coverage, East Taylor Dental Associates will file your dental claims as a courtesy to you.
  치과 보험이 있으신 경우, 저희 치과에서 보험처리를 해드릴 수 있습니다.

- Please be aware that all professional services rendered are charged directly to the Patient/Responsible Party and the Patient/Responsible Party is personally responsible for payment of fees.

모든 치료는 환자 본인이나 / 법적 보호자에 직접 청구하는 점을 유의하십시오.
환자 본인이나 법적 보호자는 비용지불에 대한 개인적 책임이 있습니다.

- We DO NOT render our services on basis that insurance companies will pay all of our fees.
  우리는 보험 회사가 비용을 모두 지불하는 것을 기준으로 치료하지 않습니다.

- All patient co-payments and deductibles, as required by your specific insurance coverage, are due and payable at the time of EACH visit.
  특정 보험에서 요구하는 모든 환자 본인 부담금및 공제금은 치료를 받으시는 날 지급하셔야 합니다.

- You are responsible for providing us with accurate insurance information at the time of service. Failure to do so could result in your claim being rejected or delayed. Repeated filing of duplicate insurance claims due to inaccurate or inadequate information provided by you may be subject to a re-filing fee of $10.00 per claim.
  당신은 정확한 보험 정보를 저희에게 제공 할 책임이 있습니다. 그렇게하지 않을 경우,
  보험회사의 결제 거부 또는 보험청구가 지연될 수 있기 때문에, 귀하가 제공한 부정확하거나 불충분 한
  정보에 의한 중복 보험 청구는 건 당 $ 10.00 의 재신청 수수료가 있을 수 있습니다.

- If payment for your claim has not been received within 45 days from the time when the claim was filed to your insurance company, you, the Patient/Responsible Party, will be responsible for any unpaid balance.
  치료에 대한 청구가 보험 회사에 제출되었을 때, 45 일 이내에 접수되지 않은 경우,
  환자분이나 보호자에게 미결제 잔액에 대한 책임이 있습니다.

- If your insurance company pays less than the estimated benefit, you will be responsible for the remaining balance.
  보험 회사가 추정 된 지불 금액보다 적은 금액을 결제하면 잔액에 대한 책임은 환자분에게 있습니다.

- If your insurance company pays more than the estimated benefit, you may have a credit balance on your account. Per your request, you may leave the credit on your account for future care or you may request a refund. East Taylor Dental Associates will make every effort to process refunds within five business days from the date the request is received. Please keep your personal information up to date, as a verifiable address must be available for us to mail checks.
  보험 회사가 추정 이익보다 더 지불하면, 차액은 환자분께 지불됩니다. 귀하의 요청에 따라,
  환불을 받으시거나, 다른 치료의 비용으로 사용하실 수 있습니다. 저희 치과는 보험액을 수령 한
  날짜로부터 5 일 이내에 환불을 처리하기 위해 최선의 노력을 다할 것입니다. 늘 저희에게 최신 개인 정보
  변동사항 (주소변경등)을 알려주시길 바랍니다.

- East Taylor Dental will make every effort to minimize bookkeeping errors. In the event that an error should occur, we will do our best to refund any credits as stated above. Should the error result in a debt owed to us, we will provide a corrected statement and will allow forty-five days for payment to be rendered in full.
  저희 치과는 회계 오류를 최소화하기 위해 최선의 노력을 다할 것입니다. 오류가 생기는 경우, 우리는
  전술 한 바와 같이 차액을 환불하기 위해 최선을 다할 것입니다. 환자분께서 치료금액을 더 지불해야
  하는 경우, 새로운 청구서를 보낼것이며, 환자는 45 일이내에 지불하셔야 합니다.

PAYMENT AGREEMENT
지불 계약

- For and in consideration of the provision of services, I accept the fee charged as a lawful debt and promise to pay said fee in full for all services at the time services are rendered.
  본인은 청구되는 모든 치료 요금을 치료한 날짜에 지불 할 것을 약속합니다.

- We accept cash, personal checks, MasterCard, Visa, American Express, or Discover Card. We do not accept post-dated checks.
  저희는 신용카드 (Master card, visa, American Express, or Discover), 현금 및 개인 수표를 받습니다. 저희는 사후 날짜 수표를 허용하지 않습니다.

- Extended payment plans and interest free financing plans are available through Care Credit and SpringStone Financing.
  Care Credit 이나 SpringStone Financing 을 통해 무이자 할부 결제방식을 사용할 수 있습니다.

- In the event payment is not received by the agreed upon dates, I understand a 1½ % finance charge (18% APR) will be added to my account and my account is subject to a $10.00 rebilling fee per each monthly statement.
  치료액이 합의된 날짜에 지불되지 않으면, 18 % 이자가 내 계정에 추가되며, 내 계좌는 월당 $10.00 의 rebilling 요금이 적용되는것에 동의합니다.

COLLECTIONS
컬렉션(수금)

- East Taylor Dental reserves the right to assess a service charge of $30.00 for all returned checks. (Or the maximum allowed by law.)
  East Taylor 치과는 모든 반환 check 에 $ 30.00 의 비용을 청구 할 수있는 권리를 보유합니다. (또는 법률에 의해 허용되는 최대).

- East Taylor Dental also reserves the right to forward any and all accounts over 90 days past due to an outside collections agency.
  East Taylor 치과는 90 일이 넘은 지체액에 대해선 다른 컬렉션(수금) 기관에 환자 계정을 전달 할 수있는 권리를 보유합니다.

- I agree to pay any cost accrued in the collection of my account, including the cost of the collection agency (33.33% of overdue balance), reasonable attorney fees and court costs, if such should be necessary.
  본인은 컬렉션 회사의 비용 (연체 잔액의 33.33 %), 합리적인 변호사 비용과 소송 비용을 포함하여 본인 계좌의 컬렉션에 발생한 모든 비용을 지불 할 것을 동의합니다.

- I authorize any employee or Agent of East Taylor Dental to contact me at any number(s), (including my cell phone) for the purpose of treatment, insurance or payment for service rendered.
  본인은 East Taylor 치과의 모든 직원이 치료, 보험 또는 지불의 목적을 위해
  본인의 모든 번호 (핸드폰포함)를 통해 연락하는 것을 허용합니다.

- I waive all rights of exemption under the Constitution and laws of the State Alabama, and any other state.
  본인은 헌법과 앨라배마주의 법률에 따른 면제나 공제의 모든 권리를 포기합니다. (앨라배마주 이외의 주법은 제외됨)

- I further authorize East Taylor Dental Associates to receive and exchange credit information.
  본인은 East Taylor 치과에 본인의 신용 정보를 받고 공유할 수 있는 권한을 부여합니다.

- I hereby authorize release of medical information for insurance claims and payment of my group insurance benefits, otherwise payable to me, to the dentist. I further agree to accept and adhere to the above office policy of East Taylor Dental Associates.
  본인은 치과 의사에게, 보험금의 지급을 위한 의료 정보의 공개를 승인합니다. 본인은 또한 East Taylor 치과의 정책에 준수 할 것을 동의합니다.

- EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, East Taylor Dental, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could results in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.
  귀하는 저희 East Taylor 치과에서 치료의 납입이나 치과 계좌에 관해 환자분께 연락시, 환자분의 기록에 있는 모든 번호로 연락할 것을 허락합니다. (핸드폰이나 다른 수신자 부담이 있을 수 있는 번호도 포함). 또한 문자나 이메일을 통한 연락을 할 수도 있으며, 음성메세지등 미리 녹음이 되어 있거나 자동 연결이 가능한 번호들도 이에 포함됩니다.

PATIENT NAME
환자 이름: _____

PATIENT, PARENT, OR GUARDIAN SIGNATURE: **RELATIONSHIP** 관계
환자, 부모, 또는 보호자 서명 : _____ _____

DATE:
날짜: _____

I, the undersigned patient and/or guarantor, understand and accept that East Taylor Dental has provided the translation of their written policies and procedures, (to the best of their knowledge), into Korean as a courtesy to me. I also fully understand and accept that the English version of East Taylor Dental's written policies and procedures are their standard legal version.
본인은 (또는 법적 보호자) East Taylor 치과에서 모든 정책이나 절차에 관해 최선을 다해 번역 서비스를 제공했음을 이해합니다. 하지만, 모든 문서는 영어로 된 버전이 법적 효용성을 갖는다는것을 이해하고 동의하여 받아들입니다.

SIGNATURE 서명 _____ **DATE** 날짜 _____

Killian J. Horner, DDS
Jennifer D. Ahn, DMD
2201 Taylor Rd.
Montgomery, AL 36117

Phone: 334-271-4600
Fax: 334-271-4709
Email: info@easttaylordental.com
Office Privacy Official: Andrea Horner

EAST TAYLOR DENTAL, PC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to maintain the privacy of protected health information, provide you with notice of our privacy practices, and to notify affected individuals following a breach of unsecured protected health information. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

The most common reason why we use or disclose your health information is for treatment, payment or health care operations.

Treatment: Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us.
Payment: Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney).
Health Care Operations: "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situation: To transfer your records to other general dentists.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation/inspection of possible violations of health care laws, government programs, and compliance with civil right laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research approved by an institutional review board or privacy board;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking

government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- to assist in disaster relief efforts;
- to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA;
- disclosures to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Individuals Involved in Your Care of Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

APPOINTMENT REMINDERS:

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will call, text, E-mail, and/or mail you an appointment reminder on a post card. We will also leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home, unless you tell us otherwise.

OTHER USES AND DISCLOSURES:

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." Your written authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of personal health information (PHI) for marketing, and for the sale of PHI. The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office privacy official named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

The law gives you many rights regarding your health information. You can/will:
- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) whom you want the limits to apply. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E -mail address. We will accommodate all reasonable requests. **However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.** If you want to ask for confidential communications, send a written request including the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.
- ask to see or to get copies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request is readily producible. You will be charged in advance a reasonable cost-based fee for making paper and electronic copies of patient information, for mailing copies in paper and electronic format, and for preparing summaries and explanations of patient information. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have

one 30 day extension of the time for us to give you access or copies if we send you a written notice of the extension. If you want to review or get copies of your health information, send a written request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.
- receive notifications of breaches of your unsecured protected health information as required by law. This office is not responsible for potential third party access to patient information sent and received via an unencrypted E-mail or E-mail address.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES:

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION:

If you want more information about our privacy practices, call or visit the office privacy official at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of our Dental Notice of Privacy Practices.
I understand that I should ask our dental practice's Office privacy official if I have any questions about these policies and procedures. ****You May Refuse to Sign This Acknowledgment****

Print Patient Name: _____

Print Parent/Guardian Name (if under the age of 18): _____

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**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)** _____

Effective Date of Notice: January 1, 2015

Dr. Killian J. Horner DDS
Dr. Jennifer D. Ahn, DMD
2201 Taylor Rd.
Montgomery, AL 36117

Phone: 334-271-4600
Fax: 334-271-4709
Email: info@easttaylordental.com
Office Privacy Official: Andrea Horner

HIPAA CONSENT
HIPAA 의 동의

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family member or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

1996 년에 통과된 건강 보험 양도 및 책임에 관한 법안 (HIPAA)는 의료 기록에 있는 개인 정보 보호를 위한 법안입니다. 저희 치과나 저희가 정한 보험 관련 업체에서 HIPAA 에 의해 보호되는 환자의 의료 기록 및 의료비 지불 관련 내역을 환자분 가족이나 지인에게 공개해야 할 수도 있습니다. 예를 들자면, 환자분께 원입해 있을시에, 배우자께서는 특정 치료가 우리 그룹의 보험으로 적용이 되는지 여부를 알기 위해서나, 치료에 관해 보험 신청에 관한 도움을 위해 저희에게 연락을 할 수 있습니다. HIPAA 법안에 따르면, 특별히 환자분께서 거부하지 않는 한, 저희는 전문적인 판단을 통해 환자분의 의료 기록 및 지불 내역을 환자분의 가족이나 지인과 논의할 수 있습니다. 그렇지만 저희는 환자분께 누구와 환자분의 의료 기록 및 지불 내역을 논의 할지에 대한 선택권을 제공하려 합니다. 다음의 세가지중 하나를 선택하여 주십시오.

☐ You may communicate with the following individuals relating to my medical or payment information.
지칭하는 다음의 사람과 본인의 의료 기록 및 지불 내역을 상의할 수 있습니다. (이름을 적어 주십시오)

_____

☐ Please do not discuss my medical or payment information with the following individuals.
다음의 사람과 본인의 의료 기록 및 지불 내역을 상의하지 마십시오. (이름을 적어 주십시오)

_____

☐ Please do not discuss my medical or payment information with anyone.
다른사람과 절대 본인의 의료 기록이나 지불 내역을 상의하지 마십시오.

_____

PATIENT NAME ***-please print***

환자 이름: _____

PATIENT, PARENT, OR GUARDIAN SIGNATURE:

환자, 부모, 또는 보호자 서명 : _____

DATE 날짜: _____