Tysons Corner
Endodontics

Welcome!

Thank you for selecting our office for your endodontic treatment and for the confidence you have placed in us. You may rest assured that we will do everything in our power to make your visit to our office as pleasant as possible. We are dedicated to the highest standards of patient care and treatment excellence. We look forward to making your treatment comfortable.

Dr. Brian A. Suh

Dr. Suh is from Ohio and is a graduate of the Ohio State University. He received his dental degree from the University of Pennsylvania School of Dental Medicine. He also completed his specialty training in Endodontics from the University of Pennsylvania School of Dental Medicine.

While at Penn, he was awarded the prestigious Samuel Rossman Award to recognize his outstanding academic and clinical achievement. Dr. Suh has achieved the highest level of knowledge and skills possible in Endodontics by becoming a Diplomate of the American Board of Endodontics. Dr. Suh lives in Potomac with his wife, Keri and children, Ellie and Alex.

Dr. Brian J. Nalls

Dr. Nalls was born and raised in Fairfax, VA. He graduated from Susquehanna University in Selinsgrove, PA. He completed his dental education and endodontic residency at the University of Pittsburgh School of Dental Medicine.

Dr. Nalls earned the American Association of Endodontics Student Achievement Award, the American Academy of Oral and Maxillofacial Pathology Student Achievement Award, the Pierre Fauchard Academy Certificate of Merit, and was inducted into Omicron Kappa Upsilon, the National Dental Honor Society. He and his wife, Lauren, enjoy the outdoors, eating at local restaurants, and attending local sporting events.

Staff + Facility

All staff members are formally trained in the most up-to-date sterilization techniques. We strictly adhere to the infection control guidelines recommended by the American Dental Association and the Centers for Disease Control. Our office is also in compliance with all OSHA regulations. All instruments, including handpieces are sterilized before use.

Payment

Every effort is being made to keep down the cost of your dental care. You can help by taking care of your account each visit. Payment in full is expected at the time treatment is rendered. **Patients not requiring a root canal will only be required to pay the consultation fee.** If for any reason root canal treatment is not completed, you will be responsible for only that portion of the treatment actually completed.

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Insurance

We accept the assignment of insurance benefits as a service to our patients who have insurance coverage that will provide payment directly to the provider. We will process and file your dental insurance claim for you. If you have partial insurance coverage, we expect payment of your estimated co-pay at the time of treatment.

Please be aware that we cannot guarantee this estimate and that there may be a balance after your insurance pays. If you have any concerns regarding your coverage, please ask the office manager prior to treatment. Any disputes concerning coverage, deductibles, co-payments and usual and customary fee schedules are strictly between you and your insurance company. Your account remains strictly your responsibility.

Late Payment

Statements are prepared when the insurance reimbursement is received, and any remaining balance is due and payable upon receipt. There is no finance charge when bills are paid when due. A late payment charge is imposed only if the balance is not paid ten (10) days after the statement due date. The late payment charge is $50 and a monthly interest of 1.5% will accrue. There is also a $30 charge for all returned checks. We reserve the right to charge $90 for missed appointments or appointments cancelled with less than 24 hours' notice.

Should this matter be turned over for collection, all costs, including a 50% collection fee, attorney fees, court costs and the cost of a private process server, if utilized, incurred by Brian A. Suh, D.M.D., P.C. shall be borne by the undersigned.

Method of Payment

For your convenience, we offer the following methods of payment. Alternative arrangements for payment must be made prior to treatment.

Please indicate which method of payment you will be using today:

- ☐ **VISA**
- ☐ **MASTERCARD**
- ☐ **AMERICAN EXPRESS**
- ☐ **CASH**
- ☐ **CHECK**
- ☐ **DISCOVER**

I authorize this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "SIGNATURE ON FILE". I understand and agree that I am completely responsible for complete payment even though I may have insurance.

_____ _____

Signature of Patient* Date

** If patient is under the age of 18, signature must be by parent or guardian.*

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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 (04/1/2003) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this 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 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 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 your 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 copies, we will charge a reasonable fee 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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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 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.

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 or 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. Brian Suh
8150 Leesburg Pike, Suite 502, Vienna, VA 22182
(703) 288-3299

PATIENT INFORMATION:

Date: _____ Referred by/Family Dentist: _____

PATIENT'S NAME: _____ GENDER: □ Male □ Female AGE: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

HOME PHONE: (____)_____-_____WORK PHONE: (____)_____-_____ CELL PHONE: (____)_____-_____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____ MARITAL STATUS: □ SINGLE □ MARRIED □ OTHER

OCCUPATION: _____ EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____ CITY, STATE, ZIP: _____

IN CASE OF EMERGENCY, NOTIFY: NAME:_____ PHONE#:_____ RELATIONSHIP: _____

Please complete the following questions in order that we may thoroughly diagnose your condition. The medical information you provide for our records is considered strictly confidential.

1. Do you have to be premedicated (prophylaxis) one hour before each dental treatment?
   □ Yes □ No

2. Have you been diagnosed as having AIDS or ARC?
   □ Yes □ No

3. Have you been hospitalized or had a serious illness within the past five years?

   _____

4. Have you had abnormal bleeding with previous extractions, surgery or trauma?

   _____

5. Please list any medications or drugs (prescribed or over the counter) you take or have taken in the last 6 months:

   _____

6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to PLEASE CIRCLE **YES (Y) OR NO (NO):**

Y	N	Novocaine	Y	N	Antibiotics	Y	N	Corticosteroids
Y	N	Codeine	Y	N	Penicillin	Y	N	Other medication
Y	N	Ibuprofen	Y	N	Metronidazole	Y	N	Latex
Y	N	Tylenol	Y	N	Clindamycin	Y	N	Previous dental

FOR WOMEN ONLY

If pregnant, number of months: _____

Are you anticipating pregnancy?	□ Yes	□ No
Are you nursing?	□ Yes	□ No
Are you taking birth control pills?	□ Yes	□ No

Please be advised that if you take antibiotics, an alternative method of birth control must be used.

PLEASE CIRCLE **YES (Y)** OR **NO (N)** TO ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Y	N	Mitral Valve Prolapse	Y	N	Implant Prosthesis
Y	N	Heart Disease or Condition	Y	N	Artificial Joint
Y	N	Heart Attack	Y	N	Lung Disease
Y	N	Prosthetic heart valves	Y	N	Asthma / Inhaler Use
Y	N	Angina	Y	N	Tuberculosis
Y	N	Bacterial Endocarditis	Y	N	Emphysema
Y	N	Bypass Surgery	Y	N	Liver Disease
Y	N	Pacemaker	Y	N	Jaundice
Y	N	Congenital Heart Disease	Y	N	Hepatitis A, B or C
Y	N	Rheumatic Heart Disease	Y	N	Kidney Trouble
Y	N	High Blood Pressure	Y	N	Renal Dialysis
Y	N	Low Blood Pressure	Y	N	Thyroid Disease
Y	N	Stroke	Y	N	GI Tract Problems
Y	N	Hives or Skin Rash	Y	N	Diabetes/ Insulin Use
Y	N	Cancer	Y	N	Blood Disorder
Y	N	Chemotherapy	Y	N	Anemia
Y	N	Radiation Therapy	Y	N	Hemophilia
Y	N	Fainting /Dizzy Spells	Y	N	Sickle Cell
Y	N	Epilepsy or Seizure	Y	N	Transfusion
Y	N	Sexually Transm. Disease	Y	N	Glaucoma
Y	N	HIV Positive	Y	N	Arthritis
Y	N	AIDS or ARC	Y	N	Migraine
Y	N	Drug Addiction	Y	N	TMJ Problem
Y	N	Alcoholism	Y	N	Ulcers
Y	N	Depression	Y	N	Colitis
Y	N	Psychiatric Care	Y	N	Sinus Problems

Do you have any condition or problem not listed above?

_____

To my knowledge, all information is complete and accurate. If there is any change I will inform the doctor immediately.

SIGNATURE:_____

DATE: _____

REVIEWED BY DENTIST: _____

DATE: _____

UPDATED/REVIEWED:_____

DATE: _____

Tysons Corner Endodontics

Patient Name_____

CONSENT TO ENDODONTIC THERAPY

Please review the following consent. You will be required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by Brian A. Suh, D.M.D., or any associates and assistants with whom he works. I agree to the use of local anesthesia, depending upon the judgment of the endodontist. Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction and that as a specialty practice, the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth to function; this will be performed by my family dentist. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

At times, medication will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness which can be increased using alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

PLEASE DO NOT WRITE IN THE SPACE BELOW UNTIL YOU HAVE TALKED TO THE DOCTOR.

Note _____

Procedure _____

Doctor _____ Assistant _____

I have read and understood the form above. I have been given the opportunity to ask questions about my treatment and any alternatives and have them fully answered by the doctor.

Please write "NONE" if all your questions were answered and you do not have further questions:

_____ _____ _____

NONE Signature of Patient* Date

** If patient is under the age of 18, signature must be by parent or guardian.*