AIR SUPPLY
ANESTHESIA

Welcome to Air Supply Anesthesia,

We consider it a great honor to be anesthesia providers and to participate in your care as an individual. We have provided these materials for you to review prior to your anesthesia experience. These materials are meant to help put you at ease and to provide an understanding of the anesthesia process. All information you provide is strictly confidential and will only be used to help us make important decisions concerning your anesthesia care. For this reason, please be completely honest while answering all the provided questions. Please feel free to reach out to us with any questions that you may have.

You may call or text us at 866.247.7759, or you may visit our website at: AirSupplyAnesthesia.com

We look forward to meeting you!

AIR SUPPLY
ANESTHESIA

Patient Identification Page

Patient Name _____ Date of Birth _____/_____/_____ Sex M / F

Height _____ Weight _____ Emergency Contact _____ Contact # _____

Patient address _____ City _____ State_____ Zip _____

Home Phone _____ Cell _____ Work _____

Email _____

Please circle

Race: Asian American Indian/Alaska Native Black/African American

Native Hawaiian/Pacific Islander White/Caucasian

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Preferred language: English Spanish Other _____

Insured's Name _____ Date of Birth _____/_____/_____

Dental Insurance Carrier _____ Subscriber ID _____

Pre-Authorization Number (if patient is 6 years or younger) _____

Health insurance carrier _____ Subscriber ID _____

Referring Dentist _____

AIR SUPPLY ANESTHESIA

HIPPA and Privacy Policy Acknowledgment Document

Patient Name _____ Date of Birth ____/____/_____

The HIPAA Privacy Rule mandates that health care providers distribute a Notice of Privacy Practices to all patients. This document outlines how protected health information about an individual may be used and disclosed and under what circumstances specific authorization from the individual may not be required. The Notice of Privacy Practices also describes the HIPAA defined patient rights related to use and disclosure of the individual's health information. Please carefully review the Air Supply Anesthesia Notice of Privacy Practices. This document is available as a hard copy in paper form and is additionally available on the website, airsupplyanesthesia.com.

We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

If you have any questions about this notice, please contact our office at 866.247.7759.

Signature of Patient_____

Print Name _____

Date _____

AIR SUPPLY
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Adult Medical History

Patient Name _____ Date of Birth _____/_____/_____ Sex M / F

Height _____ Weight _____ BMI _____ Emergency Contact _____ Contact # _____

Please answer all questions to the best of your knowledge, please list any and all medical conditions in the areas provided, your answers are strictly confidential. Your answers to these questions are vital in helping us administer general anesthesia in a safe manner.

Do you have any of the following diseases or medical problems:

1. Heart problems. Including any of the following: high blood pressure, chest pain, tightness, pressure, heart attack, irregular heart beat, pacemaker/defibrillator, circulation problems, heart failure.

Please describe: _____

2. Can you walk up two flights of stairs without stopping for rest? Y / N

3. Lung Problems. Including any of the following: history of smoking, asthma, emphysema, bronchitis, shortness of breath at rest, recent cough or cold.

Please describe: _____

4. Neurological problems. Including any of the following: stroke or mini stroke (TIA), seizures, back or neck problems, physical restrictions/limitations, multiple sclerosis, multiple dystrophy, spinal/nerve injury, neuropathy.

Please describe: _____

5. Kidney or Liver Problems. Including any of the following: diabetes, thyroid disease, kidney disease, trouble urinating, liver disease, hepatitis, heartburn (GERD, reflux),

Please describe: _____

6. Blood problems. Including any of the following: abnormal bleeding, sickle cell disease, history of blood transfusions, HIV/AIDS, anemias,

Please describe: _____

7. Any conditions from birth (congenital conditions) or syndromes. Including any of the following: Down Syndrome, autism, ADHD, developmental delay, cerebral palsy, other syndromes,

8. Please list all medications and dosages:_____

9. Please list all allergies to medications or otherwise, including food and materials such as latex:
_____

10. Please list all surgeries or anesthesia events, including any problems with anesthesia. Have any blood relatives have a history of problems with anesthesia?:
_____

I have read and understood the questions and have answered these questions truthfully and to the best of my ability.

Signature: _____ Date: _____

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Pre- and Post-Anesthetic Instructions

If you are planning to undergo dental treatment under sedation or general anesthesia, please carefully review the instructions below to help ensure a safe anesthetic experience.

Instructions Prior to Anesthesia

It very important that all food and liquids, including water, milk, breast milk be stopped midnight before the appointment. It is important that you follow these instructions as any food or liquids (along with acid) present in your stomach may be aspirated (inhaled into your lungs).
This is a potentially serious and fatal risk that is easily minimized by following our instructions and by being honest with your anesthesiologist if you have accidentally had any food or drink.
( ) Initials

You may take your medications with a small sip of water unless otherwise instructed by the anesthesiologist

If you were prescribed an antibiotic pre-medication, please take the antibiotic as scheduled at least 1 hour prior to arriving.

Please wear short sleeves, flat shoes, and comfortable shorts or pants. Contact lenses should not be worn to the office. Please remove any nail polish, make-up, lotion, oils, powders, watches, and jewelry prior to arriving to the office. Leave all valuables at home.

You must have a responsible adult drive you to the office and wait with you. Please have your driver contact information available to us as you will not be permitted to drive yourself home.

You must inform the anesthesiologist of any change in your health prior to your appointment.

No smoking for 12 hours prior to surgery.

Patient Signature _____

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Instructions Following Anesthesia

Plan to have a responsible adult drive you home. Do not plan to drive or operate potentially dangerous equipment for 24 hours after your anesthesia.

A responsible adult should be with you until the next day.

You should start drinking some water, Gatorade, or apple juice after your appointment. If you can tolerate drinking these clear fluids, you may advance your diet as tolerated. Avoid foods with dairy (e.g. milk, cheese, yogurt) and food that is too hot or too spicy. No alcoholic beverages for 24 hours after the anesthesia.

Nausea or vomiting may occur after anesthesia. If it persists beyond 4 hours, please contact your anesthesiologist.

If your temperature is persistently elevated following anesthesia, please contact your anesthesiologist

If you have any additional concerns, please contact your anesthesiologist or AirSupply Anesthesia main office at 866.257.7759.

Your Anesthesiologists contact info: _____

I have read, understand, and received a copy of these instructions.

Patient Signature_____

AIR SUPPLY
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This information is provided to inform you of the choices and risks involved with having treatment under anesthesia. This is also provided to help you feel more comfortable and enable you to be better informed concerning your treatment. There are basically four choices for anesthesia: Local anesthesia, conscious/deep sedation, general anesthesia, or no anesthesia. These can be administered, depending on each individual patient's medical status, in a hospital or in a private office. The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. You are encouraged to explore all the options available for your, or your dental procedure under anesthesia and to consult with your dentist/oral & maxillofacial surgeon or pediatrician as needed.

( ) Initials

The most frequent side effects of any general anesthetic are drowsiness, nausea and vomiting, and phlebitis (inflammation at the IV site, this may last for some time). Some patients remain drowsy or sleepy following their surgery for the remainder of the day. As a result, coordination and judgment will be impaired. It is recommended that adults refrain from activities such as driving and children remain in the presence of a responsible adult for 24 hours

( ) Initials

I understand that anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the anesthesiologist of the possibility of being pregnant or a confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For the same reason, I understand that I must inform the anesthesiologist if I am a nursing mother. ( ) Initials

I have been informed and understand that occasionally there are complications of the drugs and anesthesia including but not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, stroke, brain damage, and heart attack. I further understand and accept the risk that complications may require hospitalization and even may result in death. I have been made aware that the risks associated with local anesthesia, conscious/deep sedation, and general anesthesia will vary. ( ) Initials

I hereby authorize and request AirSupply Anesthesia to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic or anesthetics (local to general) by any route that is deemed suitable by the anesthesiologist, who is an independent contractor and consultant. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia, and that this is an independent function from the surgery/dentistry.

( ) Initials

I have been advised of and completely understand the risks, benefits and alternatives of general anesthesia. I accept the possible risks and dangers. I acknowledge the receipt of and understand both the preoperative and post-operative anesthesia instructions. It has been explained to me and I understand that there is no warranty and no guarantee as to any result and/or cure. I have had the opportunity to ask questions about my anticipated anesthesia and am satisfied with the information provided to me. It is also understood that the anesthesia services are completely independent from the operating dentist/oral and maxillofacial surgeon. The anesthesiologist assumes no liability from the surgery/dental treatment performed while under anesthesia and that the dentist/oral and maxillofacial surgeon assumes no liability from the anesthesia performed.

( ) Initials

Print Patient's Name: _____ Phone number: _____

Print Patient/Guardian Name (if applicable):_____ Date: _____

Signed: _____ Witness: _____

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FINANCIAL AGREEMENT AND POLICIES FOR ANESTHESIA SERVICES

Patient Name _____ Date _____

Procedure _____

Estimated treatment time: _____

Estimated anesthesia fee: _____

Anesthesia fees are:

- **For the first sixty minutes of care (60 mins.): $800**
- **For each additional fifteen minutes (15 mins): $200**
- **For care lasting longer than 3 hours, please contact us directly for special arrangements.**

Anticipated method of payment (circle one):

Cash Debit Visa / Mastercard Care Credit (a 10% charge will be added)

The estimated anesthesia fee is based upon the dentist's estimate of treatment time, anesthesia preparatory time and the patient's response to the anesthetic used.

Payment for anesthesia services is due the day of treatment, unless otherwise arranged. In the event anesthesia time exceeds the estimate, the patient is responsible for the additional charges. However, if the anesthesia time is less than the estimate, the patient will receive a prorated refund.

Many insurance policies do not pay for anesthesia services for dentistry. Please check with your insurance company regarding your benefits. We will be happy to provide a receipt for the anesthesia services.

A nonrefundable deposit of $500 may be collected prior to the date of the scheduled treatment. This deposit is credited toward the total anesthesia fee. Cancellation of the scheduled appointment less than 48 hours prior will result in the loss of this deposit or you will be charged a cancellation fee of $500.

I understand that if I fail to pay the fees (a returned check or failure to pay the balance in the event of a financial arrangement), I will be charged an interest of 18% APR and will be liable for all the collection charges and or court fees.

I have read, understand and agree with the above estimate of fees and policies.

Print Patient's Name_____ Phone_____

Signature of Patient_____ Date_____

HIPAA NOTICE OF PRIVACY PRACTICES

AirSupply Anesthesia, PLLC
25835 Warbler View, San Antonio, Texas 78255
866.247.7759
airsupplyanesthesia.com

AirSupply Anesthesia
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.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of AirSupply Anesthesia ("Dental or Anesthesia Practice"). "We" and "our" means the Dental Anesthesia Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact AirSupply Anesthesia's Privacy Official at:

AirSupply Anesthesia, PLLC
25835 Warbler View, San Antonio, Texas 78255
866.247.7759
airsupplyanesthesia.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;

• Give you this Notice of our legal duties and privacy practices with respect to that information; and

• Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on January 12, 2018.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, “business associates”) that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an

action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify

you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is January 12, 2018.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.