H. Coleman Burgess III, D.D.S.
1777 South 16th Street, Wilmington NC 28401
drcburgess@gmail.com **(e-mail)**
910-762-1402 910-762-8823 (Fax)

Confidential Patient Information

First Name _____
Title First Middle Last Nickname

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Mobile Phone _____

E-mail Address_____

Social Security Number _____ Date of Birth _____

Employer _____
Company Name Street Address City State Zip

Occupation/School Attending_____

If minor, name of parent or legal guardian _____

Other family treated _____

Whom may we thank for referring you to our office_____

Marital Information

[ ] Single [ ] Married [ ] Divorced [ ] Widowed

Spouse's Name _____

Spouse's Social Security Number _____ Spouse's Birth Date _____

Spouse's Employer _____
Company Name Street Address City State Zip

Emergency Medical Contact Information

Please list the nearest relative not living in your household:

Emergency Contact _____ Phone_____ Relationship_____

Address _____
Street Address City State Zip

Consent Information

Account responsibility is assumed by the person receiving treatment, unless an account guarantor has signed this information form. If the patient is a minor, the guardian present at the initial appointment is responsible for payment of any charges. I authorize insurance benefits to be paid directly to the office of H. Coleman Burgess III, DDS. I consent to the making of photographs and x-rays before, during and after treatment and to the use of same by the doctor in scientific papers or demonstrations.

_____ _____
Signature of Patient or Responsible Guardian of Minor Patient) Date

Health Information

Patient Name _____ Age _____
First Middle Last

Medical Doctor _____
Name Street Address City Zip Phone

Most Recent Physical Examination _____ Purpose of Visit _____

Preferred Pharmacy:_____

What is your estimate of your general health? [ ] Poor [ ] Fair [ ] Good [ ] Excellent

Have you ever had the following:	YES	NO
1. hospitalization for illness or injury	[]	[]
2. heart problems/cardiac stent in the last 6 months	[]	[]
3. heart murmur or infective endocarditis	[]	[]
4. rheumatic or scarlet fever	[]	[]
5. pacemaker or defibrillator	[]	[]
6. high or low blood pressure	[]	[]
7. stroke (taking blood thinners)	[]	[]
8. artificial heart valve or joint replacement	[]	[]
9. prolonged bleeding due to a slight cut	[]	[]
10. anemia or other blood disorder	[]	[]
11. emphysema, shortness of breath, emphysema	[]	[]
12. tuberculosis	[]	[]
13. asthma	[]	[]
14. sinus problems	[]	[]
15. kidney disease	[]	[]
16 liver disease	[]	[]
17. jaundice	[]	[]
18. thyroid or parathyroid disease	[]	[]
19. hormone deficiency	[]	[]
20. high cholesterol or statin drugs	[]	[]
21. diabetes (HbA1c= _____)	[]	[]
22. stomach or duodenal ulcer	[]	[]
23. digestive disorders (Celiac disease, colitis etc)	[]	[]
24. esophageal reflux or heartburn	[]	[]
25. arthritis or autoimmune disease	[]	[]
26. osteoporosis/osteopenia (taking bisphosphonates)	[]	[]
28. glaucoma	[]	[]
29. contact lenses	[]	[]
30. head or neck injuries	[]	[]
31. epilepsy, convulsions, seizures	[]	[]
32. viral infections/cold sores/HPV	[]	[]

	YES	NO
33. any lumps or swelling in mouth	[]	[]
34. hives, skin rash, hay fever	[]	[]
35. venereal disease	[]	[]
36. hepatitis type: ____	[]	[]
37. HIV/AIDS	[]	[]
38. tumor, abnormal growth	[]	[]
39. radiation therapy	[]	[]
40. Chemotherapy, immunosuppressants	[]	[]
41. emotional difficulties	[]	[]
42. psychiatric treatment	[]	[]
43. antidepressant medication	[]	[]
44. alcohol/drug dependency	[]	[]
45. ADD, ADHD, prion disease	[]	[]
Are you:		
45. presently being treated for any illness	[]	[]
46. aware of change in your general health	[]	[]
47. often exhausted or fatigued	[]	[]
48. experiencing frequent headaches	[]	[]
49. a smoker: ____ pack(s) per day	[]	[]
50. considered a touchy person	[]	[]
51. often unhappy or depressed	[]	[]
52. easily upset or irritated	[]	[]
53. Female: taking birth control pills	[]	[]
pregnant /nursing	[]	[]
54. Male: prostate disorders	[]	[]

55. Allergic to:

[] aspirin [] penicillin
[] erythromycin [] tetracycline
[] codeine [] local anesthetic
[] latex [] metals: _____
[] other: _____

Please describe any current medical treatment or other condition that may possibly affect your dental treatment:

_____

List any medications, herbal supplements or vitamins taken within the last 2 years: _____

_____

_____

Please advise us in the future of any changes in your medical history, allergies or medications.

Patient's Signature (or guardian)_____ Date_____

Doctor's Remarks:_____

_____ Doctor's Signature _____Date _____

Rev. 11-18

Dental History

Name _____Referred by _____

What is the health of your mouth? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Previous dentist:_____ How long ___/___/___

Date of last dental exam ___/___/___ last treatment ___/___/___ last x-rays ___/__/___

How often do you have your teeth cleaned? [ ]3 months [ ]4 months [ ] 6 months [ ] yearly

What is your immediate dental concern?_____

Please mark Yes or No to the following:	**Yes**	**No**
1. Unhappy/self conscious about the appearance of teeth?.....	[ ]	[ ]
2. Prior or current tooth whitening product use.....	[ ]	[ ]
3. Unfavorable past dental experiences.....	[ ]	[ ]
4. Afraid of dental care (scale 1-10 _____).....	[ ]	[ ]
5. Problems with effectiveness or bad reaction to dental anesthetic.....	[ ]	[ ]
6. Orthodontic treatment dates _____ / __ to ___ /_ _.....	[ ]	[ ]
7. Periodontal (gum) treatment dates ___/___ to ___/___	[ ]	[ ]
8. Bleeding/painful gums	[ ]	[ ]
9. Avoid brushing any part of your mouth.....	[ ]	[ ]
10. Sensitivity to [ ]hot [ ]cold [ ]brushing [ ]biting	[ ]	[ ]
11. Have you had a cavity within the last 3 years?.....	[ ]	[ ]
12. A burning sensation in your mouth..... -	[ ]	[ ]
13. Difficulty swallowing	[ ]	[ ]
14. An unpleasant taste or odor in your mouth	[ ]	[ ]
15. Dry mouth	[ ]	[ ]
16. Jaw problems (TMJ) or prior jaw treatment.....	[ ]	[ ]
17. Difficulty opening your mouth widely	[ ]	[ ]
18. Stiff neck muscles.....	[ ]	[ ]
19. Awaken with an awareness of your teeth or jaws	[ ]	[ ]
20. Tension headaches: Frequency _____	[ ]	[ ]
21. Do you feel that your jaw is pushed back when biting fully?	[ ]	[ ]
22. Do you have more than one bite or shift to bite together?.....	[ ]	[ ]
23. Clench or grind your teeth_____	[ ]	[ ]
24. Jaw clicking or popping _____	[ ]	[ ]
25. Lost or removed teeth.....	[ ]	[ ]
26. Do you sweat or tremble a lot during examination?.....	[ ]	[ ]
27. Do strange people or places make you afraid?	[ ]	[ ]
28. For wearers of removable partial or complete dentures:		
a. Denture or partial denture more than 5 years old _____	[ ]	[ ]
b. Is your present denture a problem	[ ]	[ ]
c. Satisfied with your appearance	[ ]	[ ]
d. Satisfied with the chewing ability.....	[ ]	[ ]
e. Use of denture adhesives	[ ]	[ ]

Patient's Signature (or guardian):_____ Date:_____

Please **Tell Us About You!**

NAME_____ Date _____

The better we understand you, the better we can serve you.

What is most important about your teeth to you? How important is your smile?

*Please, **circle** anything below that is important to you. Please use the back to add additional preferences for your experience in our office! THANK YOU!*

- I want lots of details about my mouth
  OR I prefer the simplest information about my mouth.
- I prefer multi-procedure appointments
  OR I prefer single procedure appointments.
- I want the best long-term treatment
  OR I want the lowest cost treatment.
- My insurance benefit dictates the limits of care I will seek
  OR I decide the care I want to have.
- I like to schedule treatment when I am in pain
  OR I like to schedule treatment before it will likely become a bigger problem.
- My home care routine is a big part of my whole health plan
  OR I rely on the dentist to fix problems.
- I prefer lots of conversation during my visit
  OR I prefer quiet time during my visits.
- I see my biggest challenges for continued dental care to be:

  the courage to come in …

  time away from other important things….

  money…

  the possible discomfort associated with treatment ….

  I don't believe that I have dental problems…

Patient Name: _____ Date: ____/____/____

Financial Arrangements for Account Guarantor:

- Depending upon your insurance coverage, payment may be required in full for services rendered at each visit. We accept Cash, Check, or Charge card (Visa, MasterCard, Discover, Lending Club or CareCredit).

- Insurance Benefit Agreement: You are responsible for the total charges for treatment regardless of insurance coverage. If your company declines your claim for any reason, the entire fee for treatment are still owed to our office. Your insurance policy is a contract between you and the insurance carrier, and our office cannot make any guarantee of payment or coverage of treatment. Your insurance company will not share specific personal information concerning your benefits with our office. Telephone or online verification of your benefits is not binding. If a claim problem arises, we encourage the patient to get involved, since you are the owner of the policy and have a contractual agreement with your insurance company.

- Assignment of Benefits: If you have dental insurance, we will file your claim and accept assignment of benefits from your primary insurance carrier (except Blue Cross Blue Shield and Delta) as a courtesy for you at no charge**. We do not accept assignment of benefits from secondary insurance policies.** Since assignment of benefits is an extension of credit, we require that your co-payment estimate be paid on the day of treatment.

- Non-Assignment of Benefits: Since we are an independent practice, some companies (Blue Cross and Delta Dental) may not mail your benefit payment to our office. For this policy coverage, we require payment of your account balance owed at each visit. As a courtesy, we will file your dental insurance claim, assigning payment to be made to you.

- Predetermination: Predetermination estimates from your insurance company are non-binding and they are under no obligation to pay what they estimate. We will file predetermination requests for a fee of $15.00 payable per request. Please allow predeterminations require 2-8 weeks for processing.

- Account Guarantor: Patients aged 18 years and older will be the responsible party for any and all financial obligations. For patients younger than 18 years of age, the responsible party must make arrangement for payment in advance of the dental appointment.

- Billing: In the event a balance remains on your account, the responsible party will be billed as follows: After 30 days from the date of service, your account will be charged a billing fee of 1.5% or $1.00, whichever is greater, per month for any unpaid balance. To avoid billing charges, payment in full must be received prior to 30 days from the date of service. This billing charge applies to all accounts, regardless of pending insurance claims.

Due to the limitations of the HIPAA Act, we cannot accept payment from your insurance company without the following information:

- **Proof of insurance eligibility for each covered family member. A current card listing each covered insured is adequate for this purpose.**
- **The policy, group, and social security number for each covered insured. Your insurance company will not process claims without this information.**
- **A valid photo identification, such as an unexpired Driver's License or ID card.**

Name(s) of your dental insurance company: _____

Group Number _____

Subscriber Number _____

Effective Date of Coverage _____

Provider Telephone Number _____

Please initial each of the following, indicating that you have read, understood and agreed to each of these requirements:

____ *I authorize the office of Dr. H. Coleman Burgess III, D.D.S. to release such information as necessary for electronic and paper filing of dental claims for my treatment and receive payment directly from my insurance company.*

____ *I understand that the office of Dr. H. Coleman Burgess III, D.D.S. is not responsible for interpretation, verification and estimation of my insurance benefit for any treatment received.* ***I understand that it is my responsibility to call my insurance company to verify coverage for treatment, deductibles, frequency limitations and other limitations of benefits.***

____ *I will supply updated insurance information prior to each visit for filing of claims. I understand that if my policy is found to not be in effect or if inadequate benefit is available, I am immediately responsible for the entire fee for services received.* ***If additional claims are required due to incorrect insurance information there will be a $15.00 charge per claim.***

____ *I agree to be responsible for the total fees charged for each visit, regardless of any insurance or third-party benefit. This means that any service not paid in full by your insurance policy requires co-payment from you as an "out-of-pocket" expense.*

____ *I understand that checks returned for non-sufficient funds will result in a $31.00 fee and be turned over for collection.*

____ *I accept responsibility for collection costs and reasonable attorney fees incurred for collection of past due balances on my account.*

____ *I understand and accept the billing procedures as noted above, including applicable billing/finance charges added to my account for balances not paid within 30 days.*

_____ _____

Signature of Account Guarantor Date

Patient's Acknowledgment Form

I, _____, acknowledge that I received and reviewed the office Privacy Policy Notice for the office of Dr. H. Coleman Burgess III. I authorize my dental information to be disclosed to the following person(s): [example: spouse, parents, grandparents, children]_____

_____
_____

Patient's signature: _____
Date: _____

In case you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for patient's refusal:

_____

_____

_____

Privacy Director's Signature:_____ Date: _____

PRIVACY POLICY NOTICE

For H. Coleman Burgess III, D.D.S., 1777 South 16th Street, Wilmington, N.C. 28401

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.

USES AND DISCLOSURES

Our office must provide you, the patient, a description and at least one example of the types of uses and disclosures that our office is permitted to make for the purposes of treatment, payment and health-care operations (all uses and disclosures, by the way that are permitted by the law without authorization by the patient).

Treatment–Our office will use and disclose your protected health information (PHI) for purposes of treatment, meaning the provision, coordination and management of your health care and related services. For instance, we will use and disclose your health information to coordinate benefits with a third-party payer, or for consultation between our office and a specialist if required for your care.

Payment– Our office will use and disclose the minimum necessary amount of your PHI to obtain payment for services rendered. For example, our office may share your treatment plan with your insurer to determine the coverage allowed by your benefits plan.

Health-care operations– Our office will use and disclose the minimum necessary amount of your PHI for health-care operations, such as business planning and development that involves conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

This section of our policy also must describe other purposes for which our office is permitted or required to use or disclose your PHI without your written authorization. No example of each of the following instances is required in this notice.

Required by law– Our office may use and disclose your PHI only to the extent that such use is required by law.

Public health activities– Our office may use and disclose the minimum necessary amount of your PHI to appropriate public health authorities for reasons such as, but not limited to, preventing or controlling disease, injury or child abuse and neglect.

Reporting abuse, neglect or domestic violence– Our office may use and disclose the minimum necessary amount of your personal health information to the extent necessary to inform the appropriate government authority if we reasonably believe you to be a victim of abuse, neglect or domestic violence.

Health oversight activities– Our office may use and disclose the minimum necessary amount of your PHI to a health oversight agency for oversight activities authorized by law, such as for, but not limited to, audits.

Judicial and administrative proceedings–Our office may use and disclose the minimum necessary amount of your PHI in the course of any judicial or administrative proceeding if required by law to do so.

Law enforcement agencies– Our office may use or disclose the minimum necessary amount of your PHI to a law enforcement agency if required by law to do so.

Deceased patients– Our office may use or disclose the minimum necessary amount of your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, another matter authorized by law, or to funeral directors to carry out their duties with respect to the deceased individual.

Research purposes–Our office may use and disclose the minimum necessary amount of your PHI for research purposes without your written authorization only if we have obtained one of the following: documented institutional review board or privacy board approval, either written or verbal representations that the information is to be used only to prepare a research protocol, either written or verbal representations that the information being sought is solely for research on the PHI of decedents, or a limited data use agreement.

Specialized government functions– If you are a member of the Armed Forces, our office will use and disclose the minimum necessary amount of your PHI for military and veteran's activities. Our office also will use and disclose the minimum necessary amount of your PHI for national security and intelligence activities, for protective services for the U.S. president and others. Our office also will use and disclose the minimum necessary amount of your PHI to a correctional institution or law enforcement agency if you are an inmate and that agency or institution indicates the information is necessary.

Safety–Our office may use or disclose the minimum necessary amount of your PHI if we believe doing so is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and other specific circumstances.

Workers' compensation proceedings– Our office may use or disclose the minimum necessary amount of your PHI as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs.

Patient directory– Except when an objection is expressed by you, our office may use or disclose the minimum necessary amount of your PHI to maintain a directory of patients in the office. Said information includes your name, your location in the office, your condition described in general terms. We will inform you in advance of any such need and give you an opportunity to object, except in cases of emergencies when we must exercise professional judgment to determine whether use and disclosure of this information is in your best interest.

Friend, family and personal representatives–Our office will use and disclose the minimum necessary amount of your PHI that is directly relevant to the involvement of a family member, other relative, a close personal friend or someone else identified by you. Involvement could be in relation to care or payment for services. Our office also will use and disclose the minimum necessary amount of your PHI regarding your location, general condition or death to a family member, a personal representative of yours or another person responsible for the your care. Such uses and disclosures will be made only with your permission if you are present, unless you are incapacitated or there is an emergency circumstance where our office must exercise professional judgment.

Federal investigation–Our office may use and disclose the minimum necessary amount of your PHI for an investigation by the U.S. Department of Health and Human Services Secretary to determine if our office is in compliance with the HIPAA privacy regulation that requires us to protect your individually identifiable health information.

Business associates–Our office may disclose the minimum necessary amount of your PHI to a business associate or allow the business associate to create or receive your PHI on our behalf only if the business associate has agreed in writing to appropriately safeguard the information.

Appointment reminders–Our office may use and disclose the minimum necessary amount of your PHI when contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Marketing–Our office will obtain written authorization from you if we would like to use your PHI for marketing purposes, except for face-to-face communications or a promotional gift of nominal value provided to you while visiting this office. This office will inform you via the written authorization form if this office is to receive remuneration in connection with any marketing purpose. You have the right to revoke any authorizations as long as you do so in writing.

General authorization statement– For any other purposes not stated in this notice, our office will not use or disclose your PHI without your prior written authorization.

PATIENT'S RIGHTS

The patient– You have the right to inspect or obtain a copy of your PHI from our office. Our office requires you to submit such requests in writing to our privacy director. Our office must act on your request no later than 30 days after receipt of your request, unless the PHI requested is not

maintained or accessible to our office on site. In the latter case, our office must respond to your request within 60 days of your request, and we must inform you of any such delay in writing within the initial 30-day timeframe. If further delays are required, our office may extend the time needed to respond to your request an additional 30 days provided that our office informs you in writing of the reasons for the delay and offers a date by which our office will respond to your request. Our office will provide you with access to your PHI to inspect or to obtain a copy, or both, in the form requested, if reasonable. If you agree to receive a summary of your PHI, our office will supply you with access to the summary. Our office will charge you a cost-based fee for the provision of any copies provided to you.

Denial of access appeals–If our office denies your request for access to your PHI in whole or in part, we must provide you with access to any other PHI for which access is not denied. For the information that is denied, our office must inform you in writing of this denial within 30 days of the original request, and the statement must provide the basis for the denial. Reasons for denial may include the following circumstances: The doctor has determined, using his professional judgment, that access to the information is reasonably likely to endanger the life or physical safety of you or another person; the information requested makes reference to another person (unless the other person is a health-care provider) and the doctor has determined, using his professional judgment, that granting your request is reasonably likely to cause substantial harm to this other person; and when the request for information is made by your personal representative and the doctor, using his professional judgment, has decided that the provision of the information to the personal representative is reasonably likely to cause substantial harm to you or another person. If access to your PHI is denied for these reasons, you have the right to have the denial reviewed by Dr. Burgess, who has agreed to serve in this capacity for our office. Dr. Burgess cannot be involved in the original decision to deny access to your PHI. Our office will inform you in writing as to the decision by Dr. Burgess within a reasonable period of time.

Restrictions– You have the right to request restrictions on certain uses and disclosures of your PHI, though our office is not required to grant such requests.

Confidential communications– You have the right to request, and our office must accommodate reasonable requests to receive confidential communications of PHI from our office by alternative means or at alternative locations.

Accounting of disclosures– You have the right to receive an accounting of disclosures of your PHI made by our office for the six years prior to the date on which the accounting is requested. The following disclosures are exempted from this accounting: Disclosures to carry out treatment, payment and health-care operations; to you, the patient; for incidental uses or disclosures; disclosures made according to your written authorization; for the office patient directory; for national security; for correctional institutions; for a limited data set; or any disclosure that occurred prior to April 14, 2003. Our office will provide you with a written accounting that includes the disclosures required to be listed, such as those to business associates of our office. This accounting will include the date of disclosure, the name of the entity or person who received the PHI.

Electronic notice– You have the right to receive a paper form of this notice of privacy policies from our office upon request if this notice was received electronically.

Right to amend– You have the right to request our office amend your PHI. Our office, however, may deny such a request if we determine that the PHI was not created by our office, is not part of the designated record set, the information is not available for access to you, or the current information is accurate and complete. Amendment requests must be made in writing to our privacy director. Our office must act on such requests within 60 days of receipt of such requests. If we deny your request, we will inform you in writing within 60 days, indicating one of the reasons listed previously as the basis for the denial. If you do not submit a statement of disagreement, you may request that our office provide your request for amendment and the denial with any future disclosures of your PHI that is the subject of the amendment. If you submit a statement of disagreement (limited to 500 words), our office may prepare a written rebuttal to your statement. We will provide you with a copy of the rebuttal.

DENTAL OFFICE DUTIES
Our office is required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Our office is required to abide by the terms of the notice currently in effect. Our office reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain.

COMPLAINTS
Patients may file a complaint with our office and with the U.S. Department of Health and Human Services Secretary if they believe their privacy rights have been violated. Complaints must be filed within 180 days of when you knew or should have known that the alleged violation occurred. To do so, please request a complaint form from our privacy director. Please be assured, patients who file complaints will not be retaliated against for doing so.

CONTACT
For more information about our office's privacy policies, contact the Privacy Director: Dr. H. Coleman Burgess III
Telephone: 910-762-1402

EFFECTIVE DATE
This notice for our practice is effective as of April 12, 2003.

Appointment Confirmation Agreement

Your appointment is considered confirmed when scheduled. Please let us know how you would like to be reminded of scheduled dental appointments:

[ ] I prefer email. My email address is_____

[ ] I prefer text messages. My cell phone number is _____

[ ] I prefer a personal phone call. The best number to reach me is _____

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance, so we can make that time available to another patient. We reserve the right to charge a $50.00 fee for all appointments cancelled within 24 hours of the appointment time. This fee must be paid prior to scheduling your next appointment.

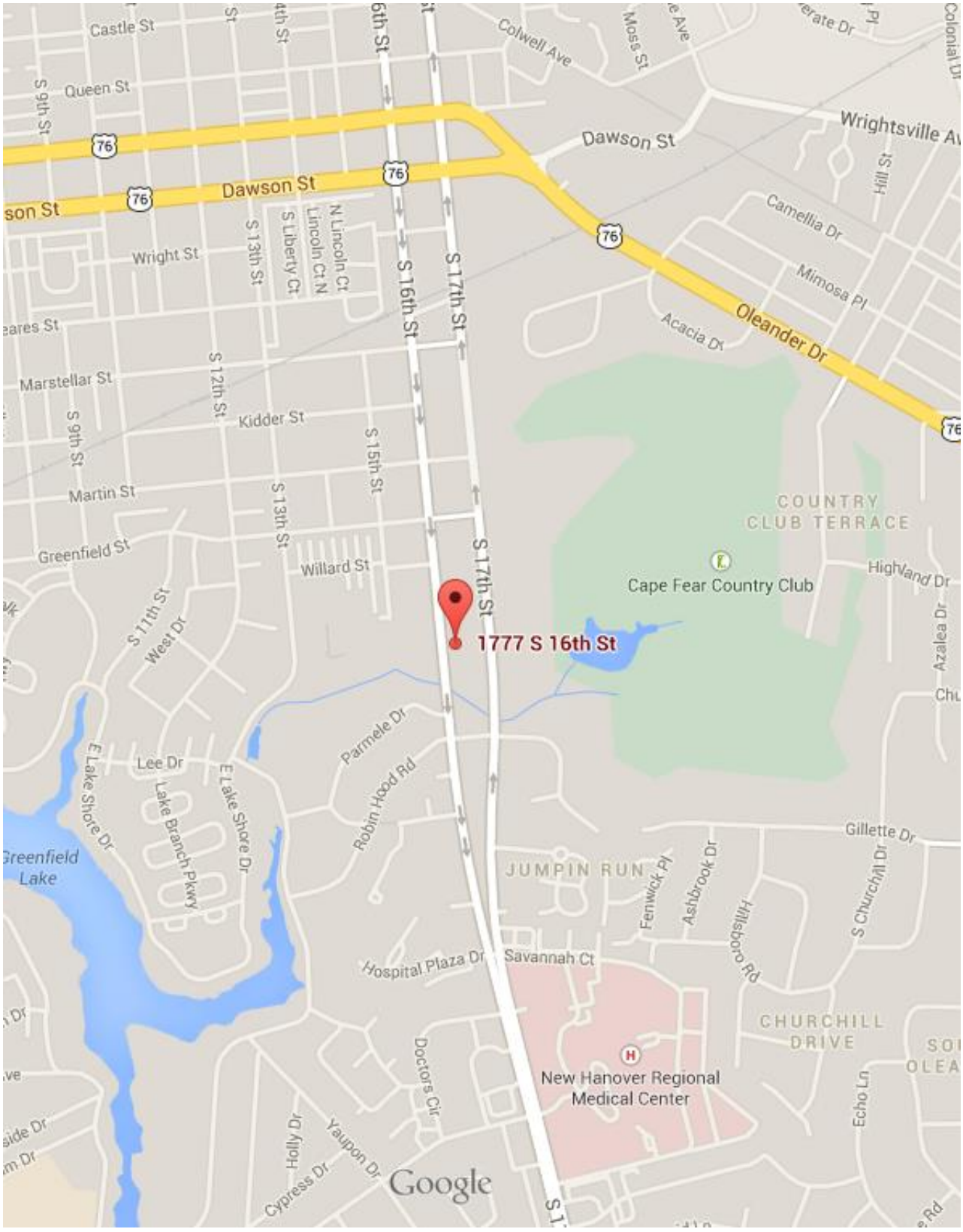
I have read and agree to abide by the terms of this confirmation policy.

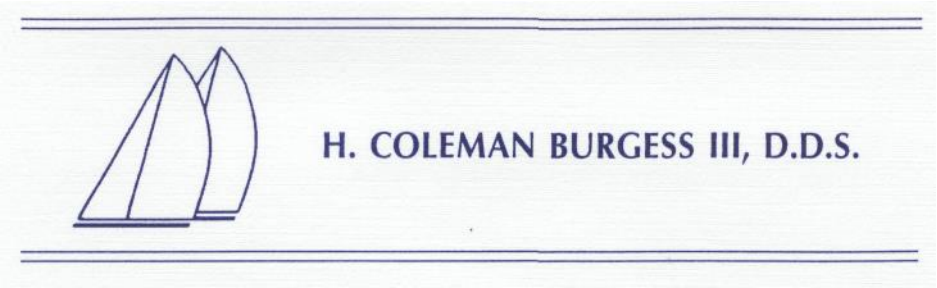
_____ _____

Patient/ Responsible party Date

Dr. Coleman Burgess

1777 South 16th Street, Wilmington NC 28403 910-762-1402





CONSENT TO USE OR DISCLOSE
DENTAL AND MEDICAL INFORMATION

1 authorize _____ to use and disclose the dental, medical,
(Name of referring or previous dentist)

and health information of _____ for the following purpose(s):
(Name of Patient)

- ☐ Treatment - Includes activities performed by a dentist or dental hygienist, as well as coordinating or managing care provided to third parties, and consultations involving dentists, physicians, and other health care providers.
- ☐ Payment - Includes activities involved in determining whether you are eligible for dental plan coverage, billing matters, and reimbursement for your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, precertification and preauthorization of services.
- ☐ Health Care Operations - Includes associated business and administrative affairs of this office.
- ☐ Other (explain) - _____

You have the right to revoke this Consent. However, you must revoke this consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to this Consent during the time frame in which this Consent is effective.

_____ _____

Date Signature of Patient

1777 SOUTH 16th STREET ☐ WILMINGTON, N.C. 28401 ☐ 762-1402