

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the

safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Regional Manager
Genny DiBlasi
1 S. School Ave.
Suite 1000
Sarasota, FL 34237
Ph #: (727) 535-5583

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

PATIENT NAME _____ **BIRTHDATE** _____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-Rays _____

Address _____

How did you find out about our office? _____

Are you satisfied with your smile? Yes No If not, do you want to improve it? Yes No

Check (✓) if you have had problems with the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot | <input type="checkbox"/> Reaction to local Anesthetic |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets | |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity when biting | |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in mouth | |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling Feet/Ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | | |
| <input type="checkbox"/> OTHER _____ | | | |

MEDICATIONS

List medications you are currently taking:

Pharmacy _____ Phone _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

PLEASE PRINT NAME of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Signature of Doctor

Date

DENTAL HEALTH HISTORY

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST MSOCIAL SECURITY # _____ BIRTHDATE ____/____/____
MM DD YYYYADDRESS _____
STREET APT.# CITY STATE ZIPTELEPHONE (____) (____) (____) _____
HOME WORK CELL E-MAILE-MAIL ADDRESS _____
(To be used for appointment confirmations and/or office promotions...your e-mail address will NOT be sold)

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER**INSURANCE INFORMATION**MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED**PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY**

LAST	FIRST	M	
STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)	RELATIONSHIP TO PATIENT		
EMPLOYER	DENTAL INS. CO		
SS#	SUBSCRIBER #	GROUP #	

Has any member of your family ever been treated in our office ? Yes No

Whom may we thank for referring you to our office ? _____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ TELEPHONE _____

ADDRESS _____
STREET APT.# CITY STATE ZIP**METHOD OF PAYMENT**Responsible party currently has an account with this office
Yes No
Payment in full at each appointment (cash or personal check)
Payment in full at each appointment (VISA MC OTHER)
Card # _____ Exp. Date _____
I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**
If I do not pay the entire new balance within ____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ____% per month (or a minimum charge of \$____ for a balance under \$____) which is an annual percentage rate of ____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.**AUTHORIZATION**

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

Date State Driver's License #

Patient Consent to receive Mail and/or Telephone Messages

Please Print (Last Name)

(First Name)

(M.I.)

Email Address (*please print*)

Do we have your permission to:

Send a recall appointment reminder to your home? Y____ N____

Leave appointment, billing or dental information on
your answering machine/voice mail/e-mail: Y____ N____

I give permission to share appointment, billing or dental information with the person named
below:

Name: _____

Signature of Patient / Parent or Legal Guardian

Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14,
2003.

Signature of Patient / Parent or Legal Guardian

Date

HIPAA CONSENT

Financial Policy

**Please note that as of June 1, 2005.
Some changes have been made to our Financial Policy.**

**All payments are due at the time services are started
unless arrangements are made prior to treatment.**

**Insurance balances are ultimately the patient's obligation.
We file (most) insurances at no cost to you as a courtesy.
We are glad to offer this service. However, insurance balances
that are not paid after 60 days may be billed directly to you.**

**Please keep your walk out statements and follow up
with your insurance to ensure payment is in process.**

**Patient balances that go unpaid for 30 days or more may
incur the following additional charges:
Interest charges (1.5% per month or 18% APR),
collection fees (up to 42% of the full balance),
and/or legal charges.**

**Major services require a deposit of at least half the
estimated patient portion at the time the appointment is made.**

**Appointments not cancelled with 48 hour notice,
may result in charges for time reserved.**

A fee of \$30.00 will be assessed for NSF checks.

Signature of patient/guardian

Date

Witnessed By