PATIENT REGISTRATION

TODAY'S DATE
WHO MAY WE THANK FOR YOUR REFERRAL?
WHAT IS YOUR RELATIONSHIP WITH THIS REFERRAL?

YOUR NAME	SPOUSE'S NAME
BIRTHDAY	BIRTHDAY
S.S. #	S.S. #
MALE ❑ FEMALE ❑	MALE ❑ FEMALE ❑
MARITAL STATUS	MARITAL STATUS
CELL PHONE	CELL PHONE
HOME PHONE	HOME PHONE
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
E-MAIL ADDRESS	E-MAIL ADDRESS
OCCUPATION	OCCUPATION
EMPLOYER	EMPLOYER
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
BUS. PHONE	BUS. PHONE

LIST CHILDREN IN THE FAMILY

NAME	BIRTHDATE
NAME	BIRTHDATE
NAME	BIRTHDATE
NAME	BIRTHDATE

EMERGENCY CONTACT PHONE
ADDRESS CITY STATE ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of the patient)_____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I release clinical and restorative dental photos taken by Brent A. Engelberg, D.D.S., P.C. and I understand that photos may be used by Brent A. Engelberg, D.D.S., P.C. for teaching, publications, and for patient education.
5. Lastly, I understand and agree that any collection or legal fees incurred by Brent A Engelberg, D.D.S., P.C., in an effort to collect debts I owe, will be my responsibility.

Patient _____ Date _____ Witness _____

Patient or Responsible Party_____ Relationship to patient _____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone_____

How often do you have dental examinations?_____

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

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name_____Phone_____
   Address _____ City_____State_____ Zip_____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis A (infectious) B (serum)	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S.	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Contact lenses	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artifical Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet (Special/ Restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychiatric/Psychological Care	Yes No

7. Do you use more than two pillows to sleep? ..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

INSURANCE/FINANCIAL POLICIES

PRIMARY INSURANCE _____	SECONDARY INSURANCE _____
INSURANCE COMPANY NAME _____	INSURANCE COMPANY NAME _____
INSURED _____	INSURED _____
GROUP NUMBER _____	GROUP NUMBER _____
MEMBER ID _____	MEMBER ID _____
CLAIMS ADDRESS _____	CLAIMS ADDRESS _____
CITY _____	CITY _____
STATE _____ ZIP CODE _____	STATE _____ ZIP CODE _____
INSURANCE PHONE _____	INSURANCE PHONE _____

PAYMENT PLANS WILL BE BASED UPON THE PRIMARY INSURANCE PAYMENT. SECONDARY INSURANCE WILL BE SUBMITTED WHEN PAYMENT OBLIGATION IS COMPLETED BY PRIMARY INSURANCE CARRIER AND PATIENT.

STATEMENTS ARE MAILED EACH MONTH. PAYMENTS NEED TO BE RECEIVED BY THE DUE DATE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

ANY CHECKS RETURNED WILL BE CHARGED A $25.00 SERVICE FEE.

WE REQUIRE 24 HOUR NOTICE FOR ANY CHANGES OR CANCELLATIONS TO YOUR APPOINTMENT OR YOUR ACCOUNT MAY BE ASSESSED A FEE.

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

IN THE EVENT PAYMENTS ARE NOT RECEIVED BY AGREED UPON DATES, I UNDERSTAND THAT 1½% / MONTH LATE CHARGE (18%APR) WILL BE ADDED TO MY ACCOUNT.

Patient _____ Date _____ Witness _____

Patient or Responsible Party _____ Relationship to patient _____

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HEALTH INFORMATION PRIVACY
POLICIES & PROCEDURES

These Health Information Privacy Policies & Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider. We implement these Health Information Privacy Policies and Procedures as a matter of sound business practice; to protect the interests of our patients; and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), its implementing regulations at 45 CFR Parts 160 and 164 (65 Fed. Reg 82462 (Dec. 28, 2000)) ("Privacy Rules"), as amended (67 Fed. Reg. 53182 [Aug. 14, 2002]), and state law that provides greater protection or rights to patients than the Privacy Rules. As a member of our workforce or as our Business Associate, you are obligated to follow these Health Information Privacy Policies & Procedures faithfully. Failure to do so can result in disciplinary action, including termination of your employment or affiliation with us. These Policies & Procedures address the basics of HIPAA and the Privacy Rules that apply in our dental practice. They do not attempt to cover everything in the Privacy Rules. The Policies & Procedures sometimes refer to forms we use to help implement the policies and to the Privacy Rules themselves when added detail may be needed. Please note that while the Privacy Rules speak in terms of "individual" rights and actions, these Policies & Procedures use the more familiar word "patient" instead; "patient" should be read broadly to include prospective patients, patients of record, former patients, their authorized representatives, and any other "individuals" contemplated in the Privacy Rules. If you have questions or doubts about any use or disclosure of individually identifiable health information or about your other obligations under these Health Information Privacy Policies & Procedures, the Privacy Rules or other federal or state law, consult Dr. Brent Engelberg, D.D.S. – at 847-259-6988 or info@ahsmiles.com, before you act.

1. General Rule: No Use or Disclosure. Our dental office must not use or disclose protected health information (PHI), except as these Privacy Policies & Procedures permit or require.

2. Acknowledgement and Optional Consent. Our dental office will make a good faith effort to obtain a written acknowledgement of receipt of our Notice of Privacy Practices (see Section 9) from a patient before we use or disclose his or her protected health information (PHI) for treatment, to obtain payment for that treatment, or for our healthcare operations (TPO). Our dental office's use or disclosure of PHI for our payment activities and healthcare operations may be subject to the minimum necessary requirements (see Section 7). Our dental office will become familiar with our state's privacy laws. If required by our state law, or as directed by the dentist, we will also seek Consent from a patient before we use or disclose PHI for TPO purposes – in addition to obtaining an Acknowledgement of receipt of our Notice of Privacy Practices. a) Obtaining Consent – If consent is to be obtained, upon the individual's first visit as a patient (or next visit if already a patient), our dental office will request and obtain the patient's written Consent for our use and disclosure of the patient's PHI for treatment, payment, and healthcare operations. Any consent we obtain must be on our Consent form, which we may not alter in any way. Our dental office will include the signed Consent form in the patient's chart. b) Exceptions – Our dental office does not have to obtain the patient's Consent in emergency treatment situations; when treatment is required by law; or when communications barriers prevent Consent. c) Consent Revocation – A patient from whom we obtain consent may revoke it at any time by written notice. Our dental office will include the revocation in the patient's chart. There is space at the bottom of our Consent form where the patient can revoke the consent. d) Applicability – Consent for use or disclosure of PHI should not be confused with informed consent for dental treatment. This section applies to our practice.

Date: [ ]

3. Authorization. In some cases we must have proper, written Authorization from the patient (or the patient's personal representative) before we use or disclose a patient's PHI for any purpose (except for TPO purposes) or as permitted or required without consent or authorization (see Sections 3, 4, or 5). Our dental office will use the Authorization form. We will always act in strict accordance with an Authorization. a) Authorization Revocation – A patient may revoke an authorization at any time by written notice. Our dental office will not rely on an Authorization we know has been revoked. b) Authorization from Another Provider – Our dental office will use or disclose PHI as permitted by a valid Authorization we receive from another healthcare provider. Our dental office may rely on that covered entity to have requested only the minimum necessary protected PHI. Therefore, our dental office will not make our own "minimum necessary" determination, unless we know that the Authorization is incomplete, contains false information, has been revoked, or has expired. c) Authorization Expiration – Our dental office will not rely on an Authorization we know has expired.

4. Oral Agreement. Our dental office may use or disclose a patient's PHI with the patient's Oral Agreement or if the patient is unavailable subject to all applicable requirements. Our dental office may use professional judgment and our experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to act on behalf of the patient to pick up dental/medical supplies, X-rays, or other similar forms of PHI.

5. Permitted Without Acknowledgement, Consent Authorization or Oral Agreement. Our dental office may use or disclose a patient's PHI in certain situations, without Authorization or Oral Agreement. In our dental office, these disclosures are not likely to be frequent. a) Verification of Identity – Our dental office will always verify the identity of any patient, and the identity and authority of any patient's personal representative, government or law enforcement official, or other person, unknown to us, who requests PHI before we will disclose the PHI to that person. Our dental office will obtain appropriate identification and, if the person is not the patient, evidence of authority. Examples of appropriate identification include photographic identification card, government identification card or badge, and appropriate document on government letterhead. Our dental office will document the incident and how we responded. b) Uses or Disclosures Permitted under this Section 5 – The situations in which our dental office is permitted to use or disclose PHI in accordance with the procedures set out in this Section 5 are listed below. • Our dental office may disclose a patient's PHI to that patient on request. • Our dental office may disclose to a patient's personal representative PHI relevant to the representative capacity. We will not disclose to a personal representative we reasonably believe may be abusive to a patient any PHI we reasonably believe may promote or further such abuse. • Our dental office will not use or disclose a patient's PHI for fundraising purposes without the patient's Authorization. • Our dental office will not use or disclose PHI for marketing without a patient's Authorization unless the marketing is in the form of a promotional gift of nominal value that we provide, or face-to-face communications between us and the patient. • Our dental office may use or disclose PHI in the following types of situations, provided procedures specified in the Privacy Rules are followed: 1. For public health activities; 2. To health oversight agencies; 3. To coroners, medical examiners, and funeral directors; 4. To employers regarding work-related illness or injury; 5. To the military; 6. To federal officials for lawful intelligence, counterintelligence, and national security activities; 7. To correctional institutions regarding inmates; 8. In response to subpoenas and other lawful judicial processes; 9. To law enforcement officials; 10. To report abuse, neglect, or domestic violence; 11. As required by law; 12. As part of research projects; and 13. As authorized by state worker's compensation laws.

6. Required Disclosures. Our dental office will disclose protected health information (PHI) to a patient (or to the patient's personal representative) to the extent that the patient has a right of access to the PHI (see Section 10); and to the U.S. Department of Health and Human Services (HHS) on request for complaint investigation or compliance review. Our dental office will use the disclosure log to document each disclosure we make to HHS.

7. Minimum Necessary. Our dental office will make reasonable efforts to disclose, or request of another covered entity, only the minimum necessary protected health information (PHI) to accomplish the intended purpose. There is no minimum necessary requirement for disclosures to or requests by one another in our dental office or by a healthcare provider for treatment; permitted or required disclosures to, or for disclosure requested and authorized by, a patient; disclosures to HHS for compliance reviews or complaint investigations; disclosures required by law; or uses or disclosures required for compliance with the HIPAA Administrative Simplification Rules. a) Routine or Recurring Requests or Disclosures – Our dental office will follow the policies and procedures that we adopt to limit our routine or recurring requests for our disclosures of PHI to the minimum reasonably necessary for the purpose. b) Non-Routine or Non-Recurring Requests or Disclosures – No non-routine or non-recurring request for or disclosure of PHI will be made until it has been reviewed on a patient-by-patient basis against our criteria to ensure that only the minimum necessary PHI for the purpose is requested or disclosed. c) Other's Requests – Our dental office will rely, if reasonable for the situation, on a request to disclose PHI being for the minimum necessary, if the requester is: (a) a covered entity; (b) a professional (including an attorney or accountant) who provides professional services to our practice, either as a member of our workforce or as our Business Associate, and who represents that the requested information is the minimum necessary; (c) a public official who represents that the information requested is the minimum necessary; or (d) a researcher presenting appropriate documentation or making appropriate representations that the research satisfies the applicable requirements of the Privacy Rules. d) Entire Record – Our dental office will not use, disclose, or request an entire record, except as permitted in these Policies & Procedures or standard protocols that we adopt reflecting situations when it is necessary. e) Minimum Necessary Workforce Use – Our dental office will use only the minimum necessary PHI needed to perform our duties.

8. Business Associates. Our dental office will obtain satisfactory assurance in the form of a written contract that our Business Associates will appropriately safeguard and limit their use and disclosure of the protected health information (PHI) we disclose to them. These Business Associate requirements are not applicable to our disclosures to a healthcare provider for treatment purposes. The Business Associate Contract Terms document contains the terms that federal law requires be included in each Business Associate Contract. a) Breach by Business Associate – If our dental office learns that a Business Associate has materially breached or violated its Business Associate Contract with us, we will take prompt, reasonable steps to see that the breach or violation is cured. If the Business Associate does not promptly and effectively cure the breach or violation, we will terminate our contract with the Business Associate, or if contract termination is not feasible, report the Business Associate's breach or violation to the U.S. Department of Health and Human Services (HHS).

9. Notice of Privacy Practices. Our dental office will maintain a Notice of Privacy Practices as required by the Privacy Rules. a) Our Notice – Our dental office will use and disclose PHI only in conformance with the contents of our Notice of Privacy Practices. We will promptly revise a Notice of Privacy Practices whenever there is a material change to our uses or disclosures of PHI to legal duties, to the patients' rights or to other privacy practices that render the statements in that Notice no longer accurate. Form 1, Notice of Privacy Practices, found in this Privacy Kit, contains the terms that federal law requires. b) Distribution of Our Notice – Our dental office will provide our Notice of Privacy Practices to any person who requests it, and to each patient no later than the date of our first service delivery after April 14, 2003. Our dental office will have our Notice of Privacy Practices available for patients to take with them. We will also post our Notice of Privacy Practices in a clear and prominent location where it is reasonable to expect patients seeking services from us will be able to read the Notice. c) Acknowledgement of Notice – Our dental office will make a good faith effort to obtain from the patient a written Acknowledgement of receipt of our Notice of Privacy Practices. Our dental office shall use Form 2, Acknowledgement of Receipt of Notice of Privacy Practices, found in this Privacy Kit, to obtain the Acknowledgement. If we cannot obtain written Acknowledgement from the patient, we will use the form to document our attempt and the reason why written Acknowledgement was not signed by the patient.

10. Patients' Rights. Our dental office will honor the rights of patients regarding their PHI. a) Access – With rare exceptions, our dental office must permit patients to request access to the PHI we or our Business Associates hold. No PHI will be withheld from a patient seeking access unless we confirm that the information may be withheld according to the Privacy Rules. We may offer to provide a summary of the information in the chart. The patient must agree in advance to receive a summary and to any fee we will charge for providing the summary. Our dental office will contact our Business Associates to retrieve any PHI they may have on the patient. b) Amendment – Patients have the right to request to amend their PHI and other records for as long as our dental office maintains them. Our dental office may deny a request to amend PHI or records if: (a) we did not create the information (unless the patient provides us a reasonable basis to believe that the originator is not available to act on a request to amend); (b) we believe the information is accurate and complete; or (c) we do not have the information. Our dental office will follow all procedures required by the Privacy Rules for denial or approval of amendment requests. We will not, however, physically alter or delete existing notes in a patient's chart. We will inform the patient when we agree to make an amendment, and we will contact our Business Associates to help assure that any PHI they have on the patient is appropriately amended. We will contact any individuals whom the patient requests we alert to any amendment to the patient's PHI. We will also contact any individuals or entities of which we are aware that we have sent erroneous or incomplete information and who may have acted on the erroneous or incomplete information to the detriment of the patient. When we deny a request for an amendment, we will mark any future disclosures of the contested information in a way acknowledging the contest. c) Disclosure Accounting – Patients have the right to an accounting of certain disclosures our dental office made of their PHI within the 6 years prior to their request. Each disclosure we make, that is not for treatment payment or healthcare operations, must be documented showing the date of the disclosure, what was disclosed, the purpose of the disclosure, and the name and (if known) address of each person or entity to whom the disclosure was made. The Authorization or other documentation must be included in the patient's record. We use the patient's chart to track each disclosure of PHI as needed to enable us to fulfill our obligation to account for these disclosures. We are not required to account for disclosures we made: (a) before April 14, 2003; (b) to the patient (or the patient's personal representative); (c) to or for notification of persons involved in a patient's healthcare or payment for healthcare; (d) for treatment, payment, or healthcare operations; (e) for national security or intelligence purposes; (f) to correctional institutions or law enforcement officials regarding inmates; or (g) according to an Authorization signed by the patient or the patient's representative; (h) incident to another permitted or required use disclosure. We will temporarily suspend the accounting of any disclosure when requested to do so pursuant according to the Privacy Rules by health oversight agencies or law enforcement officials. We may charge for any accounting that is more frequent than every 12 months, provided the patient is informed of the fee before the accounting is provided. We will contact our Business Associates to assure we include in the accounting any disclosures made by them for which we must account. d) Restriction on Use or Disclosure – Patients have the right to request our dental office to restrict use or disclosure of their PHI, including for treatment, payment, or healthcare operations. We have no obligation to agree to the request, but if we do, we will comply with our agreement (except in an appropriate dental/medical emergency). We may terminate an agreement restricting use or disclosure of PHI by a written notice of termination to the patient. We will contact our Business Associates whenever we agree to such a restriction to inform the Business Associate of the restriction and its obligations to abide by the restriction. We will document in the patient's chart any such agreed to restrictions. e) Alternative Communications – Patients have the right to request us to use alternative means or alternative locations when communicating PHI to them. Our dental office will accommodate a patient's request for such alternative communications if the request is reasonable and in writing. Our dental office will inform the patient of our decision to accommodate or deny such a request. If we agree to such a request, we will inform our Business Associates of the agreement and provide them with the information necessary to comply with the agreement. f) Applicability – Our dental office will be aware of and respect these patients' rights regarding their PHI, even though in most situations patients are unlikely to exercise them.

11. Staff Training and Management, Complaint Procedures, Data Safeguards, Administrative Practices. a) Staff Training and Management * Training – Our dental office will train all members of our workforce in these Privacy Policies & Procedures, as necessary and appropriate for them to carry out their functions. We will complete the privacy training of our existing workforce by April 14, 2003. After April 14, 2003, our dental office will train each new staff member within a reasonable time after the member starts. We will also retain each staff member whose functions are affected either by a material change in our Privacy Policies and Procedures or in the member's job functions, within a reasonable time after the change. Form 7, Staff Review of Policies and Procedures, can be used to have workforce members acknowledge they have received and read a copy of these Policies and Procedures. *Discipline and Mitigation – Our dental office will develop, document, disseminate, and implement appropriate discipline policies for staff members who violate our Privacy Policies & Procedures, the Privacy Rules, or other applicable federal or state privacy law. Staff members who violate our Privacy Policies & Procedures, the Privacy Rules or other applicable federal or state privacy law will be subject to disciplinary action, possibly up to and including termination of employment. b) Complaints – Our dental office will implement procedures for patients to complain about our compliance with our Privacy Policies and Procedures or the Privacy Rules. We will also implement procedures to investigate and resolve such complaints. The Complaint form can be used by the patient to lodge the complaint. Each complaint received must be referred to management immediately for investigation and resolution. We will not retaliate against any patient or workforce member who files a Complaint in good faith. c) Data Safeguards – Our dental office will "add to" and strengthen these Privacy Policies & Procedures with such additional data security policies and procedures as are needed to have reasonable and appropriate administrative, technical, and physical safeguards in place to ensure the integrity and confidentiality of the PHI we maintain. Our dental office will take reasonable steps to limit incidental uses and disclosures of PHI made according to an otherwise permitted or required use or disclosure. d) Documentation and Record Retention – Our dental office will maintain in written or electronic form all documentation required by the Privacy Rules for six years from the date of creation or when the document was last in effect, whichever is greater. e) Privacy Policies & Procedures – Only {name of Dentist} may change these Privacy Policies & Procedures.

12. State Law Compliance. Our dental office will comply with the privacy laws of each state that has jurisdiction over our practice, or its actions involving protected health information (PHI), that provide greater protections or rights to patients than the Privacy Rules.

13. HHS Enforcement. Our dental office will give the U.S. Department of Health and Human Services (HHS) access to our facilities, books, records, accounts, and other information sources (including individually identifiable health information without patient authorization or notice) during normal business hours (or at other times without notice if HHS presents appropriate lawful administrative or judicial process). We will cooperate with any compliance review or complaint investigation by HHS, while preserving the rights of our practice.

14. Designated Personnel. Our dental office will designate a Privacy Officer and other responsible persons as required by the Privacy Rules.

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ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I _____, have received a copy of the office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. The acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please Specify)

_____

_____

_____

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