FAMILY DENTISTRY OF MILFORD

Jiten Patel, D.D.S

100 Sussex Avenue
Milford, DE 19963
Phone: (302) 422-6924

HIPAA Notice of Privacy Practices

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.**Get an electronic or paper copy of your medical record:** • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. **Ask us to correct your medical record:** • You can ask us to correct health information about you that you think is incorrect or incomplete. • We may not be able to grant your request, but we'll tell you why in writing within 60 days.
Request confidential communications: • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.• We will say "yes" to all reasonable requests.**Ask us to limit what we use or share:** • You can ask us not to use or share certain health information for treatment, payment, or our operations.• We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. • We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information: • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.**Get a copy of this privacy notice:** • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. **Choose someone to act for you:** • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.• We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated: • You can complain if you feel we have violated your rights by contacting us using the information at the top of the page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• We will not retaliate against you for filing a complaint. **Your Choices:** For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. **In these cases, you have both the right and choice to tell us to:** • Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission: • Marketing purposes • Sale of your information
• Most sharing of psychotherapy notes **Our Uses and Disclosures:** How do we typically use or share your health information? We typically use or share your health information in the following ways.**Treat you;** • We can use your health information and share it with other professionals who are treating you.**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.**Help with public health and safety issues;** • We can share health information about you for certain situations such as:
• Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety **Do research:** • We can use or share your information for health research. **Comply with the law;** • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. **Work with a medical examiner or funeral director;** • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests; • We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions; • We can share health information about you in response to a court or administrative order, or in response to a subpoena. **Our Responsibilities;** • We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.• We must follow the duties and privacy practices described in this notice and give you a copy of it.• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

_____ _____

Signature of patient, parent or guardian Date

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Office Policies

- Our goal is to provide high quality care to our patients and respect their schedule as well. In fairness to other patients, and the office staff, we require advanced notice when changing or cancelling an appointment. **INITIAL** _____
- All appointments **MUST** be confirmed. **INITIAL**_____
- When you schedule an appointment, we reserve that time and prepare for your specific procedure. If you should need to reschedule, we kindly request that you contact us with advanced notice.
- Patients who continue to no-show and/or cancel without notice may be only allowed to schedule same day appointments.
- Any patient who is late may be considered a "no show" for their appointment and may need to be rescheduled.

I have read, understand and agree to the above appointment policy.

_____ _____

Patient or Legal Representative Signature Date

Financial Policy

- All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments or with no interest for 6 or 12 months.
- Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement unless other arrangements are made in advance. **INITIAL**_____
- A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.
- Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. I understand that this office submitting claims for payment to the insurance provider is a courtesy not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider**. INITIAL**_____

I UNDERSTAND THAT THIS OFFICE IS NOT A PARTCIPATING PROVIDER OR IN NETWORK WITH ANY INSURANCE COMPANY. INITIAL_____

- If there is dental insurance on the account, I understand that this office has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.
- Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental offices. However, it is an estimate only. Predeterminations from my insurance provider(s) are **NOT** a guarantee of payment.

I have read, understand and agree to the above financial policy.

_____ _____

Patient or Legal Representative Signature Date

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Patient's Name_____ Birth Date_____SSN#_____

Mailing Address _____City_____ State _____ Zip Code _____

Home Phone _____Cell Phone_____Email_____

Emergency Contact_____Phone_____Relationship to Pt _____

How did you hear about our office? GOOGLE FACEBOOK OTHER_____

Have you ever had any of the following? Please check all those that apply:

o HIV	o Excessive Bleeding	o Nervous Disorders	o Stroke
o Allergies_____	o Fainting	o Osteoporosis	o Thyroid Disease
o Anemia	o Glaucoma	o Pacemaker	o Tuberculosis
o Anxiety/Depression	o Head Injuries	o Parkinson's Disease	o Tumors
o Arthritis	o Heart Disease	o Defibrillator	o Ulcers
o Joint Replacement	o Mitral Valve Prolapse	o Currently Pregnant	o Codeine Allergy
o Asthma	o Heart Murmur	Due Date: _____	o Penicillin Allergy
o Blood Disease	o Heart Attack	o Radiation Treatment	o Venereal Disease
o Cancer	o High Blood Pressure	o Respiratory Problems	o Diabetes
o Jaundice	o Rheumatic Fever	o Dizziness	o Kidney Disease
o Rheumatism	o Epilepsy	o Liver Disease	o Seizure
o Mental Disorders	o Sinus Problems	o Stomach Problems	o OTHER:

Are you now under the care of a physician other than your primary? **YES NO** If Yes please explain: _____

_____

Name of Physician:_____ Phone:_____ What Medications are you currently taking? _____

Do you need to pre-medicate before a dental visit? **YES NO** Do you use tobacco products? **YES NO**

Patient or Legal Representative Signature: _____

NEW PATIENTS ONLY: Date of last dental visit_____ Have you had dental x-rays in the past 5 years? YES NO If yes please fill out the following: Name of last dentist_____Phone_____