Welcome to
Brick Dental Care

Please complete the following pages so that we can get to know you better.

Patient Information:

First Name: _____ MI: _____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Drivers License Number: _____ Marital Status: _____

Sex: ☐ Male ☐ Female

Email Address: _____

Previous Dentist: _____

EMERGENCY CONTACT: _____

Relationship: _____

Phone Number: _____

How did you hear about our office? Please mark all that apply

___Newspaper ___Location/Sign ___Radio ___Insurance Company

___Facebook ___Yelp ___TV Commercial (which channel? _____)

___Mailer ___Care Credit ___Internet Search ___Marketing Event

___Friend/Family/Staff (who can we thank? _____)

___Referring Doctor (who can we thank? _____)

Dental Insurance Information:

Subscriber Full Name (First/Last): _____

Relationship To Patient: _____ Subscriber's Phone Number: _____

Subscriber's Birth Date: _____ Subscriber's Employer: _____

Insurance Company: _____ Group Number: _____

Subscriber ID: _____ Subscriber's SS #: _____

Responsible Party (If Someone Other Than Patient)

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security Number: _____ Drivers License Number: _____

Regarding HIPAA:

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you are familiar with HIPAA privacy practices. If not, please request one from our front desk for your review.

Signature: _____ Date: _____

BRICK DENTAL CARE

Smile Evaluation

How long has it been since you were last at the dentist? ____6 months ____1-2 years ____3-5 years _____ 5+ years

What is your main concern today?

___Tooth Pain ___Sensitivity ___Broken/Cracked Teeth ___Cavities/Decay ___Cosmetic Dentistry ___Cleaning

___Missing Teeth/Implants ___Old Dentistry ___Gum Disease ___Orthodontics ___Dentures ___Whitening

___Sedation Dentistry ___Gum Recession ___Other, please list: _____

If our doctors find an issue that should be addressed immediately, are you interested in having treatment done today? _____

Do you have any anxiety, fear or bad experiences associated with the dentist office? ___yes ___no. If yes would you say that you have ___Low Anxiety ___Moderate Anxiety ___High Anxiety

Do you like the appearance of your smile and look of your teeth? ___yes ___no. If no, what would you most like to change about your smile? _____

What is most important to you when seeking dental treatment?

___Quality of Service ___Technology ___Comfort ___Fear/Sedation ___Cost ___Convenient Office Hours

___Friendliness of Staff ___Cleanliness of Office ___Other, please list: _____

Are you aware of clenching/grinding your teeth? ___yes ___no

Have you ever had periodontal gum treatment (deep cleaning or gum grafting)? ___yes ___no

Have you ever had orthodontic treatment (braces)? ___yes ___no

Have you had your wisdom teeth removed? ___yes ___no

How many times a day do you brush? _____ How many times a week do you floss? _____

Have you ever had sedation dentistry before? ___yes ___no

Are you concerned about bad breath? ___yes ___no

May we take the necessary dental x-rays in order to provide you with an accurate diagnosis? ___yes ___no

Is there anything else you would like for us to know about you? _____

_____

Eaglesoft Medical History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you take a blood thinner, Coumadin, Xaretto, Heparin?	○ Yes ○ No	
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	○ Yes ○ No	If yes	
What are your reactions?		omment	
Do you use controlled substances?	○ Yes ○ No		

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No	Sleep Apnea ○ Yes ○ No	Gastricbypass ○ Yes ○ No	

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

We welcome and appreciate the opportunity to provide for your dental needs. We do our best to provide you with superior dental and patient care. Please read this document thoroughly and sign the bottom acknowledging that you have read and understand this document. We will provide you a paper copy at the end of your visit today for your records.

Financial Guidelines: We do a complimentary insurance benefit check for those patients who have dental insurance coverage to better understand your coverage. ***It is ultimately your responsibility to be aware of your own dental coverage and provide us with as much information as possible***, in order to better assist you. We will accept assignment of benefits, paid directly to our office. ***We will estimate as closely as possible what portion your insurance will cover, but be aware that plans differ in coverage. We will collect estimated co-payments and deductibles on the day services are rendered.*** After 60 days, the balance on the account will be due in full from you if your insurance has not paid, as you are responsible for all payments made to your account. A finance charge may be added to your account after 90 days of no payments or accounts could be turned over to an outside collection agency. Patients without insurance are expected to pay in full by cash, check, or major credit cards the day services are rendered, unless financial agreements have been made prior to treatment beginning. For your convenience we do offer information for financing your dental visits from 2 months to 5 years. Please feel free to ask someone about this service.

Appointments: We make every effort to provide dental service in a timely manner. We understand that your time is valuable and want your visit to be as convenient as possible. In order to give you the most efficient care, we work within an appointment system and your appointment times are reserved especially for you. Our office hours are: Mondays Closed. Tuesdays, Thursdays and Fridays 9:00am - 6:00pm. Wednesdays 9:00am - 8:00pm and Saturdays 8:00 am - 3:00 pm. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We aim to give you the time and attention you need when in our office. Please help us achieve this goal by being punctual for your appointment. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment. ***For all operative appointments scheduled, a scheduling deposit will be required. This deposit will go towards your out of pocket cost on the day of treatment. For appointments canceled within 48 hours of scheduled appointments, this deposit will be lost.***

Cancellation Policy: I understand that if I am unable to keep my scheduled appointment for any reason, I will notify the office at least forty-eight (48) hours in advance of my scheduled appointment time. I understand that I will need to call the office and confirm my appointment within forty eight (48) hours. I understand that if I do not call the office to confirm my scheduled appointments, my appointment may be released to another patient. Please note schedule changes will be accepted only during regular office hours. I am aware that I may be charged a fee if I do not provide forty-eight (48) hours notice of cancellation or do not show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than $45.00. If you fail to show up for two (2) appointments, we may not be able to schedule you for any more appointments and you will be as a walk-in patient.

Insurance: We would like for all of our patients to better understand their dental insurance. The first thing to know is that dental insurance is not insurance at all. Insurance originated as, and is by definition, *a pooling of funds to pay for a rare, but catastrophic event*. Fire insurance is an excellent example. Originally, medical insurance was also designed this way. Payment for routine office visits, basic medications, and low deductibles are a relatively recent modification in medical policies to create additional employee benefits that are not true insurance but "tax-free" benefits.

At our office, we believe that you deserve the best in dental care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to thousands of people. Some have dental benefits, but most do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

- Your dental benefits are based upon a contract made between your employer and insurance company. If you have any questions regarding your dental benefits please contact your employer or the insurance company directly.
- Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000 & you will be surprised to know that the average dental benefit plan today still has a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in over 40 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- Many people receive notification from their insurance company that dental fees are "above usual and customary". An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in the survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary".
- Insurance companies do not recognize many routine and newer dental services. Our team will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you choose the best dentistry has to offer.
- Many plans try to confuse participants by giving the In-network as opposed to Out-of-network benefits. After reviewing many plans, the benefits only slightly vary between in-network and out-of-network. Before deciding on going to an in-network provider of your insurance, you need to evaluate the level of treatment and patient care you will be receiving. Our office only participates with Delta Dental, meaning we are in-network with only Delta Dental but will file any with any insurance.

If you understand and agree to the above guidelines for our office, please sign below.

Signature:_____ **Date:**_____

If you are signing as a personal representative of the patient, describe your relationship to the patient:

Relationship to Patient:_____ Print Name:_____

BRICK DENTAL CARE

Brick Dental Care
Medical History

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes	
Do you take, or have taken, Phen-fen or Redux?	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Are you on a special diet?	○ Yes ○ No		
Do you use tobacco?	○ Yes ○ No		
Do you use controlled substances?	○ Yes ○ No	If yes	

Women are you...

○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

○ Asprin ○ Penicillin ○ Codeine ○ Acrylic
○ Metal ○ Latex ○ Sulfa Drugs ○ Local Anesthetics

Other? ○ If yes

Do you have, or have had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatment ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressue ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congeital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Vernereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to infor the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

Brick Dental Care
1683 Route 88 Suite C
Brick, NJ 08724
(732) 475-7535

Informed Consent
General Dental Care and X-Rays

Patient Name: _____ Record #: _____

You have the right to accept or refuse dental treatment recommended by your dental provider. When a procedure or treatment requires your specific written informed consent, your dental treatment provider will have a conversation with you to describe the risks and benefits of recommended treatment, reasonable alternatives and their risks and benefits, and the risks of not pursuing the recommended treatment. You will also be required to sign an informed consent to treatment form documenting that discussion and the information you received in order to make an informed decision to accept or refuse dental care.

In addition to those procedures requiring specific individualized written informed consent, you will also come to the dental office for routine preventative care and maintenance, including dental examinations, X-rays and dental prophylaxis (cleaning) and related routine care for which the dental office will not require you to sign individualized written informed consent documents each time you visit the office.

The purpose of this form is to document your ongoing consent to routine examination, X-rays and prophylaxis each time you return for your preventative and maintenance appointments. By signing below, you authorize our office to perform any one or more of the following at each dental office visit:

- Oral Examination, Diagnosis and Treatment Planning
- Dental Prophylaxis (Cleaning) and Oral Hygiene Instructions
- Dental X-Rays

In the event you do not wish to receive any of these services, you may advise us at the time of appointment. Note that full diagnosis and treatment planning for dental conditions may require one or all of the above services, and your choice not to undergo one or more of these services at the time of any appointment may prohibit the dental provider from being able to fully identify or diagnose dental problems. This may lead to, among other things, worsening of dental conditions, periodontal (gum) disease, tooth loss and negative impact on overall oral and medical health.

I understand the recommendation of routine dental care, any fee involved, risks and benefits of treatment, any alternatives and risks and benefits of these alternatives, and consequences of not undergoing treatment. I will advise the dental professional immediately if I experience any allergic reaction or negative side effects after dental care is rendered. I have had all my questions answered and have not been offered any guarantees. I hereby give my informed written consent for routine examination, X-Rays and prophylaxis at my dental appointments.

Patient Name: _____ Date: _____

Signature: _____

If signed by a legal representative, printed name: _____

Authority: _____

Brick Dental Care
1683 Route 88 Suite C
Brick, NJ 08724
(732) 475-7535

Insurance related topics and financial responsibility
Your insurance plan requires that you present your current Insurance card at each and every visit. Although we will assist you, it is ultimately your responsibility to be aware of the extent of your coverage, limitations, and exclusions before the time of service.
Patients with insurance: Your co-payment is due on the day of service. We can only estimate your copayment because insurance plans have so much variance. If your insurance company pays less than estimated, the additional co-payment is due at that time. If your insurance company has not paid for a service within 90 days, you will agree to pay the balance due in full at that time. If your insurance company pays you and not our office, you will be required to pay for our services when rendered. If your account balance is not paid within 180 days from the day of treatment or last payment date it will be sent to a collection agency and an $18.00 collection fee will be added to your account.

Broken Appointments: A high number of broken appointments increase costs of delivering dental care for you and our other patients. With that in mind, we ask for at least 24 hours advance notice if you cannot keep your appointment. A minimum fee of $50 will be charged for a missed appointment with less than 24 hours notice. If you arrive late to your scheduled appointment, we reserve the right to reschedule the appointment.
SEPARATED/DIVORCED PARENTS
For parents who are separated or divorced and need care for their child/children, the parent bringing the child to the office authorizes treatment, and therefore is responsible for payment on the date of service. If there is a divorce decree requiring the other parent to pay a portion or all of the treatment costs incurred, it is the authorizing parent's responsibility to collect from the other parent. Brick Dental Care will not make special provisions or act as a mediator in collection of payment. Unless Brick Dental Care has a court order(s) that states the contrary, Brick Dental Care is legally obligated to disclose medical information to both parents/legal guardians. If at any time legal matters become too Intrusive for our staff, we reserve the right to dismiss the patient from the practice.

Payment Policy: Payment for treatment is made on the day the service is rendered. For extensive treatment plans, payment plans are available and must be made before treatment is started.

Grounds for Dismissal (Include but not limited to) Non-payment of patient responsible balances in timely manner Multiple missed appointments, Profane, abusive, or demeaning language to staff

Signature on file: I authorize Brick Dental Care to submit claim forms to my insurance carrier, and my signature below can take the place of an original signature on all submissions. **HIPPA Consent: I acknowledge receipt of this office's NOTICE OF PRIVACY PRACTICE.**
Signature: _____
Print Name: _____

Brick Dental Care
1683 HWY 88. Suite C
Brick, NJ, 08724
(732) 475-7535

CONSENT TO DENTAL PHOTOGRAPHY

I, _____, authorize

Dr. Gizachew or his staff, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

Dental records, dental research, dental education including lectures, seminars, demonstrations, professional publications such as journals or books, marketing material, including websites and printed materials, patient education with:

Please select one:

Full Face/Mouth ____

Or

Partial Face/Mouth ___

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature (Dentist) _____

Signature (Patient) _____

Date _____

PRIVACY POLICY NOTICE

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 type of uses and disclosures that our office is permitted to make for the purpose 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 purpose 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 may use and disclose the minimum necessary amount of your PHI and health-care operations, such as business planning and development that involves conducting cost-management and planning-related analysis related to managing and operating the entity, including formulary development and administration, development and 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 examples 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 or neglect.

Reporting abuse, neglect or domestic violence - Our office may use and disclose the minimum necessary amount of your PHI to the extent necessary to inform the appropriate public 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 to do so.

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

Deceased patients - Our office may use and disclose the minimum necessary amount of your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining cause of death or 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 veterans activities. Our office also will use and disclose the minimum 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 and 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 special circumstances.

Workers' compensation proceedings - Our office may use and 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 and disclose the minimum amount of your PHI to maintain a directory of patients in the office. Said information includes your name, your location in advance of 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 may 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 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 HIPPA privacy regulation that requires us to protect your individually identifiable health information.

Business associates - Our office may use and disclose the minimum necessary amount of your PHI to a business associate or allow the business associate to create or receive your PHI on your 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 promotional gift of nominal value provided to you while visiting the 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 authorization as long as you do so in writing.

General authorization statement - For any purpose not stated in this notice, our office will not use or disclose your PHI without your 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 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 request 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 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 0 any other PHI for which access in 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 _____ " who has agreed to serve in this capacity for our office. 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 them 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 healthcare 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 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 business associates of our office. This accounting will include the date of disclosure, the name of the entity or persons who receive the PHI.

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

Rights to amend - You have the right to request our office amend the 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 complex. 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 denial. If you do not submit a statement if disagreement, you with any future disclosures of your PHI that is the subject of the amendment. If you submit a statement if disagreement (limited to 500 words), our office may prepare a written rebuttals to your statement. We will provide you with a copy of the rebuttal.

PATIENT'S RIGHTS

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.

PATIENT'S RIGHTS

Patients may file a complaint with our office and with the 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 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:

Privacy Director: _____

Telephone: _____

EFFECTIVE DATE

This notice for our practice is effective as of: _____

BRICK DENTAL CARE

1683 ROUTE 88 STE C

BRICK, NJ 08724

(732) 475-7535

(732) 945-7998

Patient Acknowledgement Form

I, _____, acknowledge that I have received and reviewed the Office privacy notice for Amara Dental.

Patient signature _____ Date_____

Guardian signature _____ Date _____

In case you do not agree to sign this form, our office must indicate why you declined to do so. This office will not refuse treatment to anyone based solely on the patients refusal to sign the acknowledgment.

Reason for refusal

_____
_____
_____

Privacy Director's signature

_____
_____
_____