NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AN HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS CAREFULLY

The health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPAA, 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.

We may use and disclose your medical or dental records only for each of the following purposes: Treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to insurance company for payment.
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 be an internal quality assessment review.

We also may create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
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 the following rights with respect to your protected health in formation, which you can exercise by presenting a written request to the Privacy Officer:
The right to request restrictions on certain uses and disclosures of protected health information,
Including those related to disclosures of protected health information, person identified by you. We are however, not required to agree to a requested restrictions. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect a copy of your protected health information.
- The right to amend you protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

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. This notice is effective as of January 29, 2003 and we are obligated to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the term s of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Awe will post and you may request a written copy of a revised Notice of Privacy Practices from this office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For additional information, contact:

Helen Mathurin the U.S. Department of Health and Human
845 N. Michigan Ave, Suite 951 W Office of Civil Rights
Chicago, IL 60611 200 Independence Avenue, S> W>
312-787-2131 Washington, D.C. 20201
Toll Free: 1-877-696-6775

INFORMED CONSENT FOR DENTAL TREATMENT, INITIAL DIAGNOSTIC PROCEDURES:

In order to help formulate treatment recommendations, the following diagnostic procedures may be performed: (1) a medical and dental history, (2) discussion of your dental problems, concerns and desires, (3) x-rays, (4) impressions of the mouth and teeth, (5) examination of the mouth and associated structures, (6) photographs, and (7) conference with previous or concurrent treating health professionals. If additional diagnostic procedures or consultations are indicated, they will be discussed with you.

TREAMENT RECOMMENDATIONS: Are based on information gained from initial diagnostic procedures and previous experience and may vary for similar situations. The ultimate goal of treatment is to assist you in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. In those instances where the likely dental prognosis for each of these treatment plans and dental prognosis if no treatment is initiated at this time. You are welcome at any time to seek a second opinion.

REFERRAL TO OTHER SPECIALISTS: Dental restorative and prosthodontics treatment often requires concurrent treatment with other specialties such as: Periodontics, Endodontics, Anesthesiology, Orthodontics, Oral Surgery, and Physician (M.D.)

ANESTHETICS: Most procedures are performed with a local anesthetic (commonly referred to as Novocaine and Septocaine). In addition, sedative and pain medications can be used to help minimize anxiety and discomfort. In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies you may have. Some sedative or pain medication may cause drowsiness. Therefore, when these medications are used, you would need to make arrangements for transportation with another person to and from the office. Nitrous Oxide (laughing gas) is used if needed as well.

DENTAL TREATMENT DURING PREGNANCY:

Elective procedures or procedures that can be easily postponed should general wait until after childbirth. Treatment of dental pain and urgent procedures can be performed with relative safety to the fetus by minimizing the use of nitrous oxide and other medications with known fetal effects. Therefore, it is essential that you inform Dr. Abramczyk of a confirmed or suspected pregnancy.

MEDICAL HISTORY:

I understand the medical and dental history 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. I will notify Dr. Abramczyk of any change in my health or medication prior to treatment.

TREATMENT:

Upon such diagnosis, I authorize Dr. Abramczyk or the designated staff at Smile Ranch to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care.

INFORMED CONSENT AND AUTHORIZATION:

I certify that I have read and understand this Informed Consent, which outlines the general treatment considerations as well as the potential problems and complications of dental treatment. I understand that potential complications and problems may include, but are not limited to, those described in this document and discussed with me. I understand that during and following treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials or care, if it is felt this is for my best interest. In

addition, I consent that photographs and/ or videos of the procedure may be shown for teaching purposes. This consent is in force indefinitely unless revoked by Smile Ranch in writing.

CONTACTS:

I also give my permission to have Smile Ranch personally contact me and remind me of needed appointments through U.S. mail, e-mail, text messages and/ or voice messages at the number you provide as the contact.

PAYMENT:

Lastly, 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. I authorize payment directly to Smile Ranch of any insurance benefits otherwise payable to me. I authorize the release of any information relating to dental claims.

PURPOSE OF CONSENT:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I, _____, have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices (pages 5 and 6). I understand that by signing this Consent form, I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____

Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____

MEDICAL HISTORY

Name: _____ Physicians Name: _____

Are you currently under the care of a physician? *Yes* *No* Your current physical health is: *Good* *Fair* *Poor*

If yes, please explain: _____

Have you ever had any hospitalizations or surgeries? If so when and what type of surgery?_____
_____

Are you taking any prescriptions or over the counter medications? *Yes* *No*

Have you EVER taken Bisphosphonates? *Yes* *No*
Ie: Fosamax Plus D, Didronel, Aclasta, Reclast, Zometa, Boniva, Fosamax, Atelvia, Actonel, Actonel with Calcium, Aredia, Binosto, Skelid

Please list all medications: _____

Have you ever had radiation of the head and/or neck? *Yes* *No*

Do you smoke or use tobacco in any form? *Yes* *No*

Are you taking birth control pills? *Yes* *No*

Are you pregnant? *Yes* *No* week # _____

Please circle if you have had any of the following diseases or medical problems?

Abnormal Bleeding
Alcohol/ Drug Abuse
Anemia
Arthritis
Artificial Joints/ Heart Valve Problems
Asthma
Blood transfusions
Cancer/ Chemotherapy
Colitis
Congenital Heart Defect
Diabetes
Difficulty Breathing
Emphysema
Epilepsy
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack
Heart Surgery
Hemophilia
Hepatitis
Herpes/ Fever Blisters
High Blood Pressure
HIV/ AIDS
Hospitalizations
Kidney Problems
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pacemaker
Psychiatric Problems
Radiation Treatment
Rheumatic/ Scarlet Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis (TB)
Ulcers

Please list any serious medical condition (s) that you have ever had:
_____

Are you allergic to ANY of the following medicines?

Aspirin
Codeine
Dental Anesthetics
Tetracycline
Erythromycin
Latex
Penicillin
Other

Informed Consent

I understand that the information I have listed above is correct to be the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical history. I authorize Smile Ranch's dental team to perform any necessary dental treatment that I may need with my informed consent. I understand that during and following dental treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modifications in design, materials or care, if it is felt this is for my best interest. In addition, I consent that photographs and/ or videos of the procedures may be shown for teaching and educational purposes. This consent is in force indefinitely unless revoked in writing by Smile Ranch in writing.

WELCOME

We are honored you have chosen to join our amazing family of friends and patients at Smile Ranch Dentistry. The benefits of a healthy, beautiful smile are invaluable. We are dedicated to exceeding your expectations while delivering the most advanced dental care available today. If you have any questions please feel free to ask us for assistance. Welcome to The Ranch!

About You

Today's Date: _____ male female

Name: _____

Date of Birth: _____ Age: _____ SS# _____/_____/ _____

Home Phone: _____ Cell: _____

Work: _____

Home address: _____

City *state* *zip*

Employer: _____

Occupation: _____

Spouse's Name: _____

Do you have children? Yes No How many: _____

Marital status: Single Married

Email address: _____

How do you prefer we contact you? _____

Whom may we thank for referring you? _____

Consent to receive text messages from Smile Ranch ? Yes No Signature_____
-

Dental History

How can we help you today: _____

Do you require antibiotics prior to dental treatment for a hip or knee replacement or heart issues: Yes No
medication: _____

Are you currently experiencing pain with your teeth or gums: Yes No

Do you clench or grind your teeth/ have sore jaw muscles: Yes No

Do your gums bleed when you brush? Yes No

Other Services We Offer

Are you interested in any of the following: (Please circle if yes)

Gut Health	**Thermography**	**IV Vitamin C**	**Weston Price Diet**
Holistic Dental Care	**Mercury Removal**	**Cavitation Surgery**	**Remineralization**
Frenectomy	**Ozone Therapy**	**Biological Extractions**	**Homeopathy**
Laser Assisted Periodontal Therapy(LAPT)		**Massage Therapy**	**Spagyrics**
Myofunctional Orthodontics	**Biocompatibility Testing**	**Accupressure**	**Naturopathy**

Dental Insurance

Primary Dental Insurance

Co. Name: _____

Address: _____

Phone: _____ Group #: _____

Insured's name: _____

Insured's SS#: _____ Relation: _____

Date of Birth: _____ Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

Phone: _____ Group #: _____

Insured's name: _____

Insured's SS#: _____ Relation: _____

Date of Birth: _____ Employer: _____

Emergency Information:

In case of an emergency, whom would you like us to contact:

Name: _____

Home Phone: _____ Cell: _____

Work: _____ Relationship: _____

Consent to Dental Photography:

Name of Patient: _____

In connection with dental services, which I am receiving from Crystal Robyn Abramczyk, DDS, I agree and consent to allow the photographs taken before, during, and after completion of my dental treatments to be used for dental records, research, education, public relations, patient counseling or other purposes.

I further agree and consent that the photographs relating to my dental care may be published and re-published, either separately or in connection with each other in dental photo albums, professional journals, or dental books.

Date: _____

Patients Signature: _____

Witnessed by: _____

Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25 % of oral cancer victims have no such life style risk factors**. Studies also suggest that human papillomavirus (HPV) plays a role in more than 20 % of oral cancer causes. *Oral cancer risk by patient profile as follows:

- **Increased risk:**
  - **Patients ages 18-39**
  - **Sexually active patients (HPV)**
- **High risk:**
  - **Patients age 40 and older**
  - **Tobacco users (ages 18-39, any type within 10 years)**
- **Highest risk:**
  - **Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use)**
  - **Previous history of oral cancer**

We have recently incorporated VELscope powered but Sapphire into our oral screening standard of care. We find that using VELscope powered by Sapphire along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope powered by Sapphire, along with the doctor's visual exam, is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. VELscope powered by Sapphire is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope powered by Sapphire exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code DO431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $30.00.

☐ **Yes. I would prefer to have the VELscope powered by Sapphire exam at this time.**

☐ **No. I would prefer not to have the VELscope powered by Sapphire exam at this time.**

Print Name _____

Signature _____ Date _____

Cancellation/ No Show Policy

1. Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you due for a visit, due to seemingly "full" appointment book.

If an appointment is not cancelled at least 48 hours in advance you will be charged a fee of 30% for that day scheduled production. This will not be covered by your insurance company.

Credit Card Number _____

Exp Date _____ CVC _____

I, _____ understand that my credit card will be charged or I will be billed for the amount of 30% if I fail to give a 48 hour notice of cancelation.

_____ _____

Signature Date

2. Scheduled Appointment

We understand that delays can happen however we must try to keep other patients and doctors on time. If a patient is 15 minutes past their reserved time we will have to charge the patient 30% of their appointment and reschedule them.