NOTICE OF PRIVACY PRACTICES
(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) 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 oral, 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 "HIPPA", 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 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 the 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 services. An example would be an internal quality assessment review.

We may also 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 the respect to your protected health information, 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 to family members, other relatives, close personal friends, or Any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction we must abide by it unless you agree in writing to remove it.

- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend tour protected health information

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, direct my treatment, and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that it may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carryout treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

Patient Name:

_____

Signature:

_____

Relationship to Patient:

_____

Date:

_____

Buttonwood Dental LLC
Razvan D. Jordache, D.M.D.
1212 Kempton Street
New Bedford, Ma 02740-1589
Tel: (508) 999-2727

Patient Information

Name (First, Middle, Last)	Sex Date of Birth Social Security Number
Permanent Address (Street)	Marital Status
City, State & Zip Code	Spouse's or Parent's Name, Date of birth
Home Phone Work Phone	Spouse's Employer
Employer	Spouse's Insurance Co.
Dental Insurance Co. Group Number	Spouse's Social Security Number
Occupation	Spouse's Work Phone Number
Whom may we contact in an emergency	Emergency Contact Phone Number

I will be paying by_____Cash _____Check _____Credit Card

Payment Policies

Full payment is due at the time of service. We accept cash, checks, and credit cards. We offer an extended payment plan with prior approval.

Regarding Insurance

Our practice is committed to providing the best treatment for our patients. Our fees are usual and customary for treatment provided. You are responsible for payments in full, regardless of any insurance company's determination of usual and customary fees.

Extended Payment Plans

In order to keep costs down for all patients, extended payment plans are subject to late charges of 1 ½ % per month. The patient agrees that all costs of delinquent account collection, including attorney's fees, will be the responsibility of the patient.

Authorization for Treatment

I authorize Buttonwood Dental and staff to perform mutually agreed upon dental procedures and administer such anesthetics as found necessary to treat the dental condition of the above named patient. I understand and agree to the office policies outlined above, and I certify the above information is correct to the best of my knowledge.

Signed_____
Patient or Responsible Party