

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer

Telephone: (203) 743 - 4670

Fax: (203) 743 - 1756

Email: jmpaivadds@gmail.com

Address: 289 White Street, Danbury CT, 06810

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for

any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and
2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.



JOANN PAIVA-BORDUAS, D.D.S.

ALLEN H. HINDIN, D.D.S.

GREGORY M. SAAM, D.M.D.

THOMAS VALLUZZO, D.M.D.

289 WHITE STREET, DANBURY CT 06810
(203) 743-4670

The following is a statement of our Financial Policy which is provided to clearly define our office procedures regarding payment for dental services. We are committed to providing you with the best possible care. If you have dental insurance, we will do everything possible to help you receive your maximum allowable benefits. Thank you for choosing our office as your dental care provider.

Patient payment obligations are due in full at the time of service unless you have made payment arrangements in advance with our front desk staff.

Each month, you will receive a statement which, by law, is **DUE AND PAYABLE WITHIN 30 DAYS OF SERVICES RENDERED**. If payment is late due to circumstances beyond your control, you must call our office to make special arrangements. Failure to communicate an overdue account without pending insurance or a financial agreement will result in your account being turned over to a Collection Agency. The patient is responsible for all fees/costs associated with Collection procedure and will not be accepted back to our office after an account has gone to Collection.

INSURANCE - You will be required to show a copy of your insurance card at the time of service. **IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH ALL THE REQUIRED INSURANCE INFORMATION**. If we are unable to verify your insurance coverage, you are required to pay for your services when rendered. It is also your responsibility to update us with any changes. This must be done within five (5) days of services rendered.

All insurance companies have different payment policies. Your insurance policy is a contract between you and your insurance company. As a courtesy to our patients, we will submit a claim to your insurance company. You will be required to pay estimated out-of-pocket expenses and deductibles at the time of service. The out-of-pocket portion due is only as **ESTIMATE** and you will be billed for any remaining balance due in thirty (30) days. Please be aware that some, and perhaps all of the services provided may be **non-covered services**.

MINOR PATIENTS- The law states the parent seeking or authorizing dental treatment is responsible for paying the bill. Any legal agreement between the parents

Page two

has nothing to do with this practice. If payment for services is to be paid by someone else, the parent or guardian with the child should pay and have the other party reimburse him/her.

MISSED APPOINTMENTS- Please call our office as soon as possible if you must cancel or reschedule an appointment. If you **NO-SHOW** without calling, you may be charged a \$25.00-\$75.00 broken appointment fee.

Thank you for reading our **Financial Policy**. We will be happy to answer any questions you may have. We believe communication with our patients is very important. Please do not hesitate to speak to our front desk staff.

**I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY.
I GUARANTEE PAYMENT OF ALL CHARGES INCURRED FOR
THE ACCOUNT OF THE BELOW PATIENT. I FURTHER AGREE
TO PAY ANY ATTORNEY FEES, COURT COSTS, AND RELATED
COLLECTION FEES INCURRED.**

Print patient name Responsible Party Signature: Date

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1

ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS #: _____

Home Address: _____

APT./CONDO #: _____

CITY STATE ZIP
 Single Married Divorced Widowed Separated

Hm #: (____) _____ Pager / Cell #: _____

Wk #: (____) _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

(Please Circle)

Last Visit Date: _____

2

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: ____ SS #: _____

Birthdate: ____ / ____ / ____ Driver's License #: _____

Person Responsible for Account: _____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3

INSURANCE COVERAGE

Primary

Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____ Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

4

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

CONTINUED ON BACK

4

MEDICAL HISTORY *continued*

Your current physical health is: Good Fair Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- | | |
|--|----------------------------------|
| Y N Abnormal Bleeding | Y N Hepatitis |
| Y N Alcohol / Drug Abuse | Y N Herpes / Fever Blisters |
| Y N Anemia | Y N High Blood Pressure |
| Y N Arthritis | Y N HIV+ / AIDS |
| Y N Artificial Bones / Joints / Valves | Y N Hospitalized for Any Reason |
| Y N Asthma | Y N Kidney Problems |
| Y N Blood Transfusion | Y N Liver Disease |
| Y N Cancer /Chemotherapy | Y N Low Blood Pressure |
| Y N Colitis | Y N Mitral Valve Prolapse |
| Y N Congenital Heart Defect | Y N Pacemaker |
| Y N Diabetes | Y N Psychiatric Treatment |
| Y N Difficulty Breathing | Y N Radiation Treatment |
| Y N Emphysema | Y N Rheumatic / Scarlet Fever |
| Y N Epilepsy | Y N Seizures |
| Y N Fainting Spells | Y N Shingles |
| Y N Frequent Headaches | Y N Sickle Cell Disease / Traits |
| Y N Glaucoma | Y N Sinus Problems |
| Y N Hay Fever | Y N Stroke |
| Y N Heart Attack | Y N Thyroid Problems |
| Y N Heart Murmur | Y N Tuberculosis (TB) |
| Y N Heart Surgery | Y N Ulcers |
| Y N Hemophilia | Y N Venereal Disease |

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

Are you allergic to any of the following?

- | | | |
|------------------------|------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Metals |
| Y N Codeine | Y N Jewelry | Y N Penicillin |
| Y N Dental Anesthetics | Y N Latex | Y N Tetracycline |

Please list any other drugs/materials that you are allergic to: _____

5

DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No Do your gums ever bleed? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Would you like whiter teeth? Yes No Fresher breath? Yes No

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

Type of bristles? Soft Medium Hard

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



I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.



If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature _____ Date _____

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

- Date: _____ Comments: _____ Signature: _____
- Date: _____ Comments: _____ Signature: _____
- Date: _____ Comments: _____ Signature: _____