CONSENT OF OFFICE POLICY

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and use appropriate medication and therapy indicated for such treatment in connection with _____ (patient name).

3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine and payable at the time services are rendered unless other arrangements have been made in advance. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be applied to my account in addition to any collection charges.

4. I understand that where appropriate, credit bureau reports may be obtained.

5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

6. I authorize the use of my Social Security number to be used in the filing of my dental claim.

_____ _____

Signature Date

ACKNOWLEDGMENT OF PATIENT RESPONSIBILITY

The Dental Touch is proud to offer expert assistance in maximizing your insurance benefits and filing your claims. We work with many insurance companies and will verify your insurance plan with our selected list of quality dental insurance programs. Our insurance department will provide as much information regarding your policy as possible however payment for services is always the responsibility of the policy holder. Please keep in mind that you are responsible for any less fees or amounts not covered under your policy. Any applicable co-pays will be collected prior to appointment.

1. I agree to pay any portion of the fees not covered by my insurance company for **ANY** reason. **I understand that any prior balance or co-pays due will be collected prior to services being rendered.**

2. I understand that The Dental Touch can only **ESTIMATE** the approximate percentage or amount that my insurance company will pay. I understand that any balance remaining on my account after 30 days due to non-payment is based on the quality of care for patients, not the standard set by any insurance company.

3. **I understand that it is my responsibility to know the plan guidelines in reference to cleanings, fluorides and exams for my family members and myself.** I understand that The Dental Touch will recommend treatment based on the quality of care for patients, not the standard set by any insurance company.

4. Fees quoted remain effective for **90 days** and are subject to change if treatment does not begin within this 90 day period.

5. I understand that if treatment has begun and not completed in which The Dental Touch incurs lab fees, the office reserves the right to adjust the balance on my account and charge for temporary services (including doctor time and lab fees), and that if I do not complete treatment as recommended the previous adjustments will apply, while any monies rendered will be retained to cover those fees.

6. I understand that The Dental Touch will keep and apply any monies I have paid toward treatment initially. Treatment not completed within 90 days of the start date (unless otherwise specified) will be considered incomplete treatment and the aforementioned adjustments will apply. Treatment resumed at a later date will be assessed a fee at my next scheduled appointment or when billed by The Dental Touch.

7. **I understand that The Dental Touch has a 48-hour cancellation policy and will charge an appropriate fee for appointments that are cancelled within less than 48 hours**. Appointments cancelled the same day of service or broken appointments without notification will be charged a fee. I understand that I will be responsible for payment of fees at my next scheduled appointment or when billed by The Dental Touch.

8. I understand that The Dental Touch will be happy to duplicate and make available to me at my request any x-rays that have been taken for the purpose of diagnosis. **I acknowledge that The Dental Touch will need a minimum of 48 hours' notice for any duplicate request.** I understand that The Dental Touch will keep original x-rays on file and I will receive a duplicate copy. **I agree to pay the minimum duplication fee of $16.00 for these copies and sign a record release form as required by law.**

_____ _____

Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgment)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for The Dental Touch. A copy of this signed and dated Acknowledgment shall be as effective as the original.

_____ _____

Printed Name Signature

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our Privacy Official, _____.

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

____ It was emergency treatment

____ I could not communicate with the patient

____ The patient refused to sign

____ The patient was unable to sign

Explanation:

_____ _____

Signature of Privacy Official Date

CONSENT FOR HIPAA AUTHORIZATION

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom the information may be released (name(s) or class(es) of recipients):

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as to the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility. (For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____

Patient Signature Date

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____

Relationship to Patient Printed Name

_____

Source of Authority

CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

I, _____ (hereafter "Patient") hereby authorize Shireen Dhanani, DMD and The Dental Touch (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning Patient in accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

_____ _____

By Patient Date

Or

_____ _____

By Patient's Representative Date

Note: Do not use this form for disclosure of HIV, Substance Abuse or Psychotherapy Notes.

NOTICE OF PRIVACY PRACTICES

1. Your Information 2. Your Rights 3. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Your Rights-You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices-You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures-We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement and other government requests
- Respond to lawsuits and legal actions

More detailed information on each of these three areas follows:

1. 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, in a timely manner, without delay for legal review, usually within 30 days of your request. We may charge a reasonable cost-based fee for copying as authorized by the Florida Board of Dentistry but we will not condition copying upon payment of a fee for services rendered.

Ask us for your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will 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 will provide one accounting per year for free but with 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. We will provide you with a paper copy promptly.

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 listed at the bottom of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services. Upon request, we will provide you with the address to file a complaint with the U.S. Department of Health and Human Services.
- We will not retaliate against you for filing a complaint.

2. 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 the 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 unable 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 and the written permission specifically lists the type of information being disclosed and prevents re-disclosure:

- Marketing purposes
- Sale of your information
- Most sharing of notes regarding psychotherapy, HIV and/or substance abuse

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

3. 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.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run Our Organization
We can use and share your health information to run our practice, improve your care and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for Your Services
We can use and share your information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.
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 are complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
- We can share 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.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.
Other Information

- We do not create or manage a hospital directory.
- We do not create or maintain a psychotherapy and/or substance abuse information at this practice.
- We do not receive financial remuneration for marketing products or services in this practice.
- We do not sell patient information in this practice.

- We do not engage in fundraising at this practice.
- We do not engage in research studies at this practice.
- We may ask about HIV status because it is pertinent to your dental care but will make no further disclosure of such information without specific written consent from you or as otherwise required by law.
- We will never share any psychotherapy, HIV or substance abuse records without your written permission. A general authorization for release of records is not sufficient for us to release this type of information. We will ask you to sign a separate written consent form that specifically mentions this type of information before we release this type of information. If you direct us to release this type of information, we will instruct the recipient that further disclosure by the recipient requires your specific written consent.
- Under Florida law, we are unable to submit claims to payers (your health plan) under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing a Consent form but, unless you pay in full out-of-pocket, we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it.
- Effective Date of this Notice is September 23, 2013.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, have a question or have a concern about your personal information, please contact us as indicated below:

Our Privacy Official: Shireen Dhanani, DMD
Telephone: 352-728-8300
Fax: 352-728-8400
Address: 918 E. Dixie Ave. Leesburg, FL 34748
Email: Leesburg@mydentaltouch.com