DR . FARZANEH AND ASSOCIATES

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ____/____/____, and will remain in effect until 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 the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public

health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health 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.

Contact Officer: Dr. S. Farzaneh

Telephone: 616 Trapelo Rd. Fax:

E-mail: Waltham, MA 02452

Address: _____

Dr. Farzaneh and Associates

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print

Name:_____

Signature:_____

_

Date:_____

_

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Dr. Sally Farzaneh And Associates
616 Trapelo Rd.
Waltham, MA 02492

Acknowledgement of Receipt of HIPAA Privacy Policies and Procedures

I, _____, have received and reviewed a copy of _____ [PRACTICE 'S] health information privacy and security policies and procedures.

Print Name_____

Signature_____

Date_____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations _____ Preventive Services _____ Restorations _____

Crowns _____ Bridges _____ Other _____ Patient Initials _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials _____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials ____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

_____ _____

Patient Signature Date

REGISTRATION AND TREATMENT

Dr. Sally Farzaneh
616 Trapelo Road
Waltham, MA 02452

PATIENT INFORMATION					
Last Name		First Name		MI	Soc. Sec.#
Address					
City		State	Zip		Telephone
Sex [ ]M [ ]F	Age	Birthday	[ ]Single [ ]Married [ ]Widowed [ ]Separated [ ]Divorced		
Patient Employer					Occupation
Business Address					Business Phone
E-mail:					
Whom May We Thank For Referring You?					
In Case Of Emergency Whom Should We Notify?					Phone

PRIMARY INSURANCE			
Person Responsible for The Account	Last Name	First Name	MI
Relation To Patient	Birthday	Soc. Sec.#	
Address(if different from patient's)		Phone	
City	State	Zip	
Person Responsible Employed By:		Business Phone:	
Insurance Company		Soc. Sec.#	
Contact #	Group#	Subscriber#	
Names of Other Dependents Covered By This Plan			

ADDITIONAL INSURANCE		
Is Patient Covered By Additional Insurance?		
Subscriber Name	Relationship To Patient	Birthday
Address (if different from patient's)		Phone
City	State	Zip
Subscriber Employed By		Business Phone
Insurance Company		Soc. Sec.#
Contact #	Group#	Subscriber#
Names Of Other Dependents Covered By This Plan		

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payments of benefits.

I understand that I am responsible for all charges whether or not paid by insurance.

Signature:X_____ Date:_____

Medical History

Date _____

MEDIC ALERT

The following information is required by the dentist to assist in proper diagnosis and treatment.

ALL INFORMATION IS CONFIDENTIAL

	Yes	Don't know /Maybe	No
1. Have you ever had a serious illness requiring hospitalization or extensive medical care?_____ Specify: _____	☐	☐	☐
2. Are you presently under the care of a physician?_____ Dr.'s Name: _____ Telephone #: _____	☐	☐	☐
3. Have you had a medical examination in the last year? _____	☐	☐	☐
4. Do you use any prescription or non-prescription medicine regularly?_____ Specify: _____	☐	☐	☐
5. Do you have any allergic condition: i.e. asthma, hay fever, skin rash, food allergies? _____	☐	☐	☐
6. Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea?_____ Specify: _____	☐	☐	☐
7. Have you been hospitalized in the last 5 years?_____	☐	☐	☐
8. Have you ever experienced any unusual reaction to any of the following? (Please circle)_____ local anesthesia (freezing), aspirin, penicillin, iodine. Sulfonamide, barbiturates (sleeping pills). or any other medicine? If so, explain: _____	☐	☐	☐
9. Have you been warned against taking any drug or medication? _____	☐	☐	☐
10. Do you have or have you ever had any of the following? (please check)_____	☐	☐	☐

☐ Heart murmur or mitral valve prolapse	☐ Malignant hyperthermia	☐ AIDS	☐ Hepatitis A/B/C	☐ Liver disease
☐ Stomach/intestinal problems	☐ Drug/alcohol addiction	☐ Positive testing for HIV virus	☐ Herpes	☐ Cortisone/steroid therapy
☐ Joint replacement (hip, knee etc.)	☐ Venereal disease	☐ Jaundice	☐ Heart attack	☐ Other
☐ Mental or nervous disorder	☐ Any lung disease	☐ Diabetes	☐ Cold sores	_____
☐ High/low blood pressure	☐ Thyroid disease	☐ Tuberculosis	☐ Cancer	_____
☐ Hyper (hypo) glaucemia	☐ Arthritis or rheumatism	☐ Stroke	☐ Kidney disease	_____
☐ Epilepsy or seizures	☐ Scarlet or rheumatic fever		☐ Sinus trouble	

11. Have you ever had any known contact with the AIDS virus? _____	☐	☐	☐
12. Has any member of your family had diabetes? _____	☐	☐	☐
13. Do you bruise easily or bleed abnormally? _____	☐	☐	☐
14. Do your ankles swell during the day? _____	☐	☐	☐
15. Have you had any weight changes recently? _____	☐	☐	☐
16. Do you have any blood disorders such as anemia (thin blood). thalassaemia (major, minor)? _____	☐	☐	☐
17. Have you ever had radiation treatment or chemotherapy? _____ If so, explain:_____	☐	☐	☐
18. Have you ever had any injury, surgery or x-ray therapy to your face or jaw? _____	☐	☐	☐
19. Do you have frequent severe headaches? _____	☐	☐	☐
20. Do you have frequent earaches, ear/throat infections or any hearing difficulties? _____	☐	☐	☐
21. Is your eyesight: ☐ Good ☐Adequate ☐ Poor Do you wear contact lenses? _____	☐	☐	☐
22. Are you on a special diet? _____	☐	☐	☐
23. Have you ever fainted? _____	☐	☐	☐
24. Do you ever experience shortness of breath or chest pain when walking or climbing stairs? _____ If so, explain: _____	☐	☐	☐
25. Have you had any organ transplants or medical implants? _____	☐	☐	☐
26. Do you have any disease, condition or problem that you think the doctor should know about? _____ If so, explain: _____	☐	☐	☐
27. Is there anything about yourself that we should be made aware? _____ If so, explain: _____	☐	☐	☐
28. Have you ever had a persistent cough for greater than three weeks? _____	☐	☐	☐
29. Has your cough ever produced blood? _____	☐	☐	☐
30. **WOMEN ONLY** - Are you pregnant?_____ If so which month are you in?_____	☐	☐	☐
Are you taking any birth control pills? _____	☐	☐	☐
Have you ever had problems with pregnancy, delivery and the use of oral contraceptives? _____	☐	☐	☐

TO AVOID COMPLICATIONS, PLEASE NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR MEDICAL CONDITION