NU DENTAL

Welcome to Nu Dental

Please complete the following pages so that we can get to know you better.

Patient Information:

First Name: _____ MI: ____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Drivers License Number: _____ Marital Status: _____

Sex: ☐ Male ☐ Female

Email Address: _____

Previous Dentist: _____

EMERGENCY CONTACT: _____

Relationship: _____

Phone Number: _____

How did you hear about our office? Please mark all that apply

___Newspaper ___Location/Sign ___Radio ___Insurance Company

___Facebook ___Yelp ___TV Commercial (which channel? _____)

___Mailer ___Care Credit ___Internet Search ___Marketing Event

___Friend/Family/Staff (who can we thank? _____)

___Referring Doctor (who can we thank? _____)

Dental Insurance Information:

Subscriber Full Name (First/Last): _____

Relationship To Patient: _____ Subscriber's Phone Number: _____

Subscriber's Birth Date: _____ Subscriber's Employer: _____

Insurance Company: _____ Group Number: _____

Subscriber ID: _____ Subscriber's SS #: _____

Responsible Party (If Someone Other Than Patient)

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security Number: _____ Drivers License Number: _____

Regarding HIPAA:

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you are familiar with HIPAA privacy practices. If not, please request one from our front desk for your review.

Signature: _____ Date: _____

NU DENTAL

Smile Evaluation

How long has it been since you were last at the dentist? ____6 months ____1-2 years ____3-5 years _____ 5+ years

What is your main concern today?

___Tooth Pain ___Sensitivity ___Broken/Cracked Teeth ___Cavities/Decay ___Cosmetic Dentistry ___Cleaning

___Missing Teeth/Implants ___Old Dentistry ___Gum Disease ___Orthodontics ___Dentures ___Whitening

___Sedation Dentistry ___Gum Recession ___Other, please list: _____

If our doctors find an issue that should be addressed immediately, are you interested in having treatment done today? _____

Do you have any anxiety, fear or bad experiences associated with the dentist office? ___yes ___no. If yes would you say that you have ___Low Anxiety ___Moderate Anxiety ___High Anxiety

Do you like the appearance of your smile and look of your teeth? ___yes ___no. If no, what would you most like to change about your smile? _____

What is most important to you when seeking dental treatment?

___Quality of Service ___Technology ___Comfort ___Fear/Sedation ___Cost ___Convenient Office Hours

___Friendliness of Staff ___Cleanliness of Office ___Other, please list: _____

Are you aware of clenching/grinding your teeth? ___yes ___no

Have you ever had periodontal gum treatment (deep cleaning or gum grafting)? ___yes ___no

Have you ever had orthodontic treatment (braces)? ___yes ___no

Have you had your wisdom teeth removed? ___yes ___no

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

Have you ever had sedation dentistry before? ___yes ___no

Are you concerned about bad breath? ___yes ___no

May we take the necessary dental x-rays in order to provide you with an accurate diagnosis? ___yes ___no

Is there anything else you would like for us to know about you? _____

_____

Medical History

Are you under a physician's care now? ☐ Yes ☐ No

If yes: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes: _____

Have you ever had a serious head or neck or back injury? ☐ Yes ☐ No

If yes: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

If yes: _____

Do you take, or have taken Phen-Fen or Redux? ☐ Yes ☐ No

If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

If yes: _____

Do you take a blood thinner, Coumadin, Xaretto, or Heparin? ☐ Yes ☐ No

If yes: _____

Are you on a special diet? ☐ Yes ☐ No

If yes: _____

Do you use tobacco/nicotine? ☐ Yes ☐ No

If yes: _____

Do you use controlled substances? ☐ Yes ☐ No

If yes: _____

Women:

Are you Pregnant/Trying to get pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Acrylic ☐ Metal

☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other? _____

What were your reactions to the allergen? _____

Medical History

Do you or have you had any of the following?

AIDS/HIV	Y N	Diabetes	Y N	Hepatitis A, B or C	Y N	Rheumatism	Y N
Alzheimer's Disease	Y N	Drug Addiction	Y N	High Blood Pressure	Y N	Scarlet Fever	Y N
Anaphylaxis	Y N	Easily Winded	Y N	High Cholesterol	Y N	Shingles	Y N
Anemia	Y N	Emphysema	Y N	Hives/Rash	Y N	Sickle Cell Disease	Y N
Angina	Y N	Epilepsy/ Seizures	Y N	Hypoglycemia	Y N	Sinus Trouble	Y N
Arthritis/Gout	Y N	Excessive Bleeding	Y N	Irregular Heartbeat	Y N	Spina Bifida	Y N
Artificial Heart Valve	Y N	Excessive Thirst	Y N	Kidney Problems	Y N	Stomach/ Intestinal Disease	Y N
Artificial Joint	Y N	Fainting/Dizzy Spells	Y N	Leukemia	Y N	Sleep Apnea	Y N
Asthma	Y N	Frequent Cough	Y N	Liver Disease	Y N	Stroke	Y N
Blood Disease	Y N	Frequent Diarrhea	Y N	Low Blood Pressure	Y N	Swelling of Limbs	Y N
Blood Transfusion	Y N	Frequent Headaches	Y N	Lung Disease	Y N	Thyroid Disease	Y N
Breathing Problems	Y N	Gastric Bypass	Y N	Mitral Valve Prolapse	Y N	Tonsillitis	Y N
Bruise Easily	Y N	Genital Herpes	Y N	Osteoporosis	Y N	Tuberculosis	Y N
Cancer	Y N	Glaucoma	Y N	Pain in Jaw Joints	Y N	Tumors/Growths	Y N
Chemotherapy	Y N	Hay Fever	Y N	Parathyroid Disease	Y N	Ulcers	Y N
Chest Pains	Y N	Heart Attack/Failure	Y N	Psychiatric Care	Y N	Venereal Disease	Y N
Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Radiation Treatments	Y N	Yellow Jaundice	Y N
Congenital Heart Disorder	Y N	Heart Pacemaker	Y N	Recent Weight Loss	Y N		
Convulsions	Y N	Heart Trouble/Disease	Y N	Renal Dialysis	Y N		
Cortisone Medicine	Y N	Hemophilia	Y N	Rheumatic Fever	Y N		

Have you ever had any serious illness not listed? _____

By signing below I acknowledge that to the best of my knowledge the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health and it is my responsibility to inform the dentist of any changes to my medical health.

Patient/Guardian Signature: _____ Date: _____

Office and Financial Policies

Financial Guidelines: We do a complimentary insurance benefit check for those patients who have dental insurance coverage to better understand your coverage. It is ultimately your responsibility to be aware of your own dental coverage and provide us with as much information as possible in order for us to better assist you. We will accept assignment of benefits, paid to us directly. We will estimate as closely as possible what portion your insurance will cover, but please be aware that plans differ in coverage and it is not a guarantee of coverage. We will collect estimated copayments and deductibles on the day services are rendered. After 60 days, the balance on your account will be due in full in the event your insurance has paid less than estimated, denied coverage and has not paid for dental services, you will be required to pay for the balance on your account. A finance charge may be added to your account if after 90 days there have been no payments made and after 180 days your account will be turned over to an outside collection agency with an additional fee applied to your account. Patients without insurance are expected to pay in full by cash, check or major credit cards the day services are rendered. There is also a credit card service fee of 2.5% or 3.5% for American express that is applied to all debit and credit card transactions. For your convenience we participate with a variety of financial services that we can help you apply for to utilize as payment towards treatment.

Appointments: We make every effort to provide dental services in a timely manner. We understand that your time is valuable and want your visit to be as convenient as possible. In order to give you the most efficient care we work with an appointment system that reserves appointment times especially for you. We make every effort to honor all time commitments and expect our patients to extend the same courtesy to us. We aim to give you the time and attention you need when in our office, please help us achieve this goal by being punctual for appointments. Should you arrive more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for treatment. If you fail to confirm your dental appointment, we will assume you are not attending and may reschedule your appointment to accommodate other patients. For operative appointments a scheduling deposit may be required, this deposit will go towards your out of pocket cost on the day of treatment. This deposit may be lost for the appointment being canceled within 48 hours of your scheduled appointment.

Broken/Canceled Appointment Policy: While we understand conflicts may arise, cancellation of your appointment with less than a 24-hour notice or failing to show up without informing us, may result in a charge of at least $50 per hour to your account.The fee may vary depending on appointment type and length of appointment but it will not be less than $50. Please be aware that schedule changes will only be accepted during business hours. The cancellation of 2 consecutive appointments will result in us not being able to schedule any future appointments and you may only be seen for same day/walk-in availability.

Separated/Divorced Parents: For parents who are separated or divorced and need care for their child/children, the parent bringing the child to the office authorizes treatment, and therefore is responsible for payment on the date of service treatment is being rendered. If there is a divorce decree requiring the other parent to pay a portion or all of the treatment cost incurred, it is the authorizing parents responsibility to collect from the other parent. Nu Dental will not make special provisions or act as a mediator in collection of payment. Unless Nu Dental has a court order(s) that states the contrary, Nu Dental is legally obligated to disclose medical information to both parents/legal guardians. If at any time legal matters become too intrusive for our staff, we reserve the right to dismiss the patient from the practice.

Grounds For Dismissal: At Nu Dental, we are committed to providing quality healthcare services to all of our patients. We believe in treating every individual with respect, dignity, and fairness. Our goal is to create a welcoming and inclusive environment where patients from all backgrounds feel valued and supported. To ensure the well-being of our patients and maintain a harmonious practice we reserve the right to dismiss any patient from the practice who exhibits the following behaviors that are included but not limited to: non-payment for account balances in a timely manner, multiple missed appointments, profane, abusive, or demeaning language to staff and being under the influence of alcohol or controlled substances while on our premises.

By signing below, I acknowledge that I have read this document thoroughly and understand Nu Dental's office policies. I affirm that I agree to abide by all the policies listed in order to become and remain a patient at this practice.

_____ _____

Patient/Guardian Signature Date

Understanding Dental Insurance

At Nu Dental, we believe that you deserve the best in dental care. That is why we always present you with the best solution to treat your personal situation. Each year we provide outstanding dental care to thousands of patients, some of which have dental benefits but most do not. If you have dental benefits, congratulations! You are very fortunate and here are some important things to know:

- Dental insurance is a form of health insurance designed to pay a portion of the costs associated with dental care. There are several different types of individual, family, or group dental insurance plans grouped into three primary categories: Indemnity, Preferred Provider Network (PPO), and Dental Health Managed Organizations (DHMO). Here at Nu Dental we only participate with PPO insurance plans.
- Unlike medical insurance, dental insurance does not provide significant protection against unexpected or unaffordable costs. Medical insurance often pays a large portion of expenses after a deductible or copay has been met. Dental insurance, on the other hand, is designed to be only an aid or supplement to help with your dental care.
- Generally dental offices have a fee schedule, or a list of prices for the dental services or procedures they offer. Dental insurance companies have similar fee schedules which are based on Usual and Customary (UCR) dental services, which is an average of fees in a geographical area. The fee schedule is used as the transactional instrument between the insurance company, dental office and/or dentist, and the patient.
- Insurance companies spend a lot of money on marketing and promotion, giving customers the impression they'll pay up to 80%, even 100%, of their dentists' fees. Despite what you may have been told, we find that many plans cover anywhere from 40% to 60% of an average dental fee. For the same procedure, some plans pay more and some pay less. Ultimately, the amount paid by insurance is determined by how much your employer paid for the plan. The less the employer paid for the insurance, the less you'll receive in benefits.
- Many plans may try to confuse participants by giving them the in-network as opposed to out-of-network benefits. After reviewing many plans the benefits usually only slightly vary between in-network and out-of-network providers. Before deciding on going to an in-network provider of your insurance, it is important to evaluate the level of treatment and patient care you will be receiving before making any final decisions. Quality of care is not guaranteed or determined by your insurance plan but by the quality of work by the provider.
- Insurance companies often "downgrade" or apply an "alternate benefit" to procedures in order to pay less for certain procedures such as fillings, crowns, dentures and bridges. An example of this is when your plan will only pay for a tooth-colored (composite) filling at the rate it would pay a silver (amalgam) filling. Most dentists including Nu Dental no longer use amalgam to fill teeth. We want to provide you with the best dental care, the same thing we want for ourselves which is why we only use the best materials for your dental needs.

We will do everything we possibly can to help you maximize your dental benefits every year and If you have questions about your dental plan, we will gladly help you find the answers. Ultimately, it is still your responsibility to be aware of your own dental coverage and provide us with as much information as possible in order for us to better assist you. We will estimate as closely as possible what portion your insurance will cover, but please be aware that plans differ in coverage and the estimate provided is not a guarantee of coverage. In the event your insurance has paid less than estimated, denied coverage and has not paid for dental services you will be required to pay for the balance on your account.

By signing below I authorize Nu Dental to submit dental claims to my insurance carrier and my signature below can take the place of an original signature on all submissions which may be listed as "Signature on File". I acknowledge that I have read this form thoroughly and understand all the information provided.

_____ _____

Patient/Guardian Signature Date

Informed Consent for General Dental Care and X-Rays

You have the right to accept or refuse dental treatment recommended by your dental provider. When a procedure or treatment requires your specific written informed consent, your dental treatment provider will have a conversation with you to describe the risks of not pursuing the recommended treatment. You will also be required to sign an informed consent to treatment form documenting that discussion and the information you received in order ro make an informed decision to accept or refuse dental care.
In addition to those procedures requiring specific individualized written informed consent, you will also come to the dental office for routine preventative care and maintenance, including dental examinations, x-rays, and dental prophylaxis (cleaning) and related routine care for which the dental office will not require you to sign individualized written informed consent documents each time you visit the office.

The purpose of this form is to document your ongoing consent to routine exams, x-rays and prophylaxis each time you return for your preventative and maintenance appointments. By signing below, you authorize our office to perform any one of the following at each dental visit:

- Oral Examination, Diagnosis, and Treatment Planning
- Dental Prophylaxis (Cleaning) and Oral Hygiene Instructions
- Dental Radiographs (x-rays)

In the event you do not wish to receive any of these services, you may advise us at the time of the appointment. Note that full diagnosis and treatment planning for dental conditions may require one or all of the above services, and dental providers from being able to fully identify or diagnose dental problems. This may lead to among other things, worsening of dental conditions, periodontal (gum) disease, tooth loss, and negative impact on overall and medical health.

By signing below I understand the recommendation of routine dental care, any fee involved, risks and benefits of treatment, any alternatives and risks and benefits of these alternatives, and consequences of not undergoing treatment. I will advise the dental professional immediately if I experience any allergic reaction or negative side effects after dental care is rendered. I have had all my questions answered and have not been offered any guarantees. I hereby give my informed written consent for routine examination, x-rays, and prophylaxis at my dental appointments.

_____ _____

Print Patient/Guardian Name Date

_____

Patient/Guardian Signature

CONSENT FOR DENTAL RADIOGRAPHS (X-RAYS)

Dental radiographs, commonly known as X-rays, are an important part of your dental care. They are used to help dentists diagnose diseases of the teeth and surrounding tissue that cannot be seen with a simple oral exam. They also help the dentist find and treat dental problems early on, which can help save you money, unnecessary discomfort, and maybe even your life.

Benefits of dental x-rays

Dental x-rays are an important diagnostic tool that allows your dentist to see between and inside your teeth. They will help your dentist find and treat various dental problems before they become too serious or advanced such as: size, and position of the teeth, tooth decay, bone loss caused by periodontal disease which can lead to tooth loss, infections located in the tooth, tooth roots and beneath the gums, cysts/tumors, abscessed teeth, other pathologic root resorption, bone pathologies and much more

Radiation

The amount of radiation that a patient receives during dental x-rays is very small when compared to other sources of radiation in everyday life such as using your cell phone, a microwave, etc. While digital x-rays do emit a very small amount of radiation, we take all necessary precautions to ensure exposure is minimal (lead apron, collar,etc).

Pregnancy

In the case of pregnant women, x-rays will be taken only if the benefits outweigh the risks. Please inform us if you are or may be pregnant

Finances

We recommend x-rays be taken during your 6 month dental visits to help diagnose and treat any dental issues as quickly as possible. Without periodic radiographs, the dentist cannot identify and disclose potential problems, which could lead to serious jaw infections, tooth loss, and bone destruction. While we understand your insurance plan may or may not cover these x-rays, your dental care is our top priority and we will not compromise the health of our patients to meet insurance standards. In the event your insurance company denies payment of the x-rays you will be responsible for the out of pocket cost.

By signing below, I hereby acknowledge and understand the information indicated on this form provided by Nu Dental and its associates. I understand the importance of dental radiographs, the risks associated with not taking them and have chosen to receive these services. I also understand that I will be financially responsible for any out of pocket cost should my insurance deny payment. I hereby acknowledge that I have been given the opportunity to ask questions regarding the nature and purpose of my treatment and have received answers to my satisfaction. In the event I choose to refuse dental x-rays, I voluntarily assume any and all possible risks including but not limited to those listed as a result of this decision.

□ **I give my consent for the proposed treatment as described above.**

_____ _____

Print Patient/Guardian Name Date

_____

Patient/Guardian Signature

PRIVACY POLICY NOTICE

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.

USES AND DISCLOSURES

Our office must provide you, the patient, a description and at least one example of the type of uses and disclosures that our office is permitted to make for the purpose of treatment, payment and health-care operations (all uses and disclosures by the way, that are permitted by the law without authorization by the patient.)

Treatment - Our office will use and disclose your protected health information (PHI) for purpose of treatment, meaning the provision, coordination and management of your health care and related services. For instance, we will use and disclose your health information to coordinate benefits with a third-party payer, or for consultation between our office and a specialist if required for your care.

Payment - Our office may use and disclose the minimum necessary amount of your PHI and health-care operations, such as business planning and development that involves conducting cost-management and planning-related analysis related to managing and operating the entity, including formulary development and administration, development and improvement of methods of payment or coverage policies.

This section of our policy also must describe other purposes for which our office is permitted or required to use or disclose your PHI without your written authorization. No examples of each of the following instances is required in this notice.

Required by law - Our office may use and disclose your PHI only to the extent that such use is required by law.

Public health activities - Our office may use and disclose the minimum necessary amount of your PHI to appropriate public health authorities for reasons such as, but not limited to, preventing or controlling disease, injury or child abuse or neglect.

Reporting abuse, neglect or domestic violence - Our office may use and disclose the minimum necessary amount of your PHI to the extent necessary to inform the appropriate public government authority if we reasonably believe you to be a victim of abuse, neglect or domestic violence.

Health oversight activities - Our office may use and disclose the minimum necessary amount of your PHI to a health oversight agency for oversight activities authorized by law, such as for, but not limited to, audits.

Judicial and administrative proceedings - Our office may use and disclose the minimum necessary amount of your PHI in the course of any judicial or administrative proceeding if required to do so.

Law enforcement agencies - Our office may use and disclose the minimum necessary amount of your PHI to a law enforcement agency is required by law to do so.

Deceased patients - Our office may use and disclose the minimum necessary amount of your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining cause of death or another matter authorized by law, or to funeral directors to carry out their duties with respect to the deceased individual.

Research purposes - Our office may use and disclose the minimum necessary amount of your PHI for research purposes without your written authorization only if we have obtained one of the following documented institutional review board or privacy board approval, either written or verbal representations that the information is to be used only to prepare a research protocol, either written or verbal representations that the information being sought is solely for research on the PHI of decedents, or a limited data use agreement.

Specialized government functions - If you are a member of the Armed Forces, our office will use and disclose the minimum necessary amount of your PHI for military and veterans activities. Our office also will use and disclose the minimum amount of your PHI for national security and intelligence activities for protective services for the U.S. President and others. Our office also will use and disclose the minimum necessary amount of your PHI to a correctional institution or law enforcement agency if you are an inmate and that agency or institution indicates the information is necessary.

Safety - Our office may use and disclose the minimum necessary amount of your PHI if we believe doing so is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and other special circumstances.

Workers' compensation proceedings - Our office may use and disclose the minimum necessary amount of your PHI as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs.

Patient directory - Except when an objection is expressed by you, our office may use and disclose the minimum amount of your PHI to maintain a directory of patients in the office. Said information includes your name, your location in advance of such need and give you an opportunity to object, except in cases of emergencies when we must exercise professional judgment to determine whether use and disclosure of this information is in your best interest.

Friend, family and personal representatives - Our office may use and disclose the minimum necessary amount of your PHI that is directly relevant to the involvement of a family member, other relative, a close personal friend or someone else identified by you. Involvement could be in relation to care or payment for services. Our office also will use and disclose the minimum necessary amount of your PHI regarding your location, general condition or death to a family member, a personal representative of yours or another person responsible for your care. Such uses and disclosures will be made only with your permission if you are present, unless you are incapacitated or there is an emergency circumstance where our office must exercise professional judgment.

Federal investigation - Our office may use and disclose the minimum necessary amount of your PHI for an investigation by the U.S. Department of Health and Human Services Secretary to determine if our office is in compliance with the HIPPA privacy regulation that requires us to protect your individually identifiable health information.

Business associates - Our office may use and disclose the minimum necessary amount of your PHI to a business associate or allow the business associate to create or receive your PHI on your behalf only if the business associate has agreed in writing to appropriately safeguard the information

Appointment reminders - Our office may use and disclose the minimum necessary amount of your PHI when contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Marketing - Our office will obtain written authorization from you if we would like to use your PHI for marketing purposes, except for face-to-face communications or promotional gift of nominal value provided to you while visiting the office. This office will inform you via the written authorization form if this office is to receive remuneration in connection with any marketing purpose. You have the right to revoke any authorization as long as you do so in writing.

General authorization statement - For any purpose not stated in this notice, our office will not use or disclose your PHI without your written authorization.

PATIENT'S RIGHTS

The patient - You have the right to inspect or obtain a copy of your PHI from our office. Our office requires you submit such requests in writing to our privacy director. Our office must act on your request no later than 30 days after receipt of your request, unless the PHI request is not maintained or accessible to our office on site. In the latter case, our office must respond to your request within 60 days of your request, and we must inform you of any such delay in writing within the initial 30-day timeframe. If further delays are required, our office may extend the time needed to respond to your request an additional 30 days provided that our office informs you of the reasons for the delay and offers a date by which our office will respond to your request. Our office will provide you with access to your PHI to inspect or to obtain a copy, or both, in the form requested, if reasonable. If you agree to receive a summary of your PHI, our office will supply you with access to the summary. Our office will charge you a cost-based fee for the provision of any copies provided to you.

Denial of access appeals - If our office denies your request for access to your PHI in whole or in part, we must provide you with access 0 any other PHI for which access in not denied. For the information that is denied, our office must inform you in writing of this denial within 30 days of the original request, and the statement must provide the basis for the denial. Reasons for denial may include the following circumstances: The doctor has determined, using his professional judgment, that access to the information is reasonably likely to endanger the life or physical safety of you or another person; the information requested makes reference to another person (unless the other person is a health-care provider) and the doctor has determined, using his professional judgment, that granting your request is reasonably likely to cause substantial harm to this other person; and when the request for information is made by your personal representative and the doctor, using his professional judgment, has decided that the provision of the information to the personal representative is reasonably likely to cause substantial harm to you or another person. If access to your PHI is denied for these reasons, you have the right to have the denial reviewed by _____" who has agreed to serve in this capacity for our office. cannot be involved in the original decision to deny access to your PHI. Our office will inform you in writing as to the decision by them within a reasonable period of time

Restrictions - You have the right to request restrictions on certain uses and disclosures of your PHI, though our office is not required to grant such requests.

Confidential communications - You have the right to request, and our office must accommodate reasonable requests to receive confidential communications of PHI from our office by alternative means or at alternative locations.

Accounting of disclosures - You have the right to receive an accounting of disclosures of your PHI made by our office for the six years prior to the date on which the accounting is requested. The following disclosures are exempted from this accounting: Disclosures to carry out treatment, payment and healthcare operations; to you, the patient; for incidental uses or disclosures; disclosures made according to your written authorization; for the office patient directory; for national security; for correctional institutions; for limited data set; or any disclosure that occurred prior to April 14,2003. Our office will provide you with a written accounting that includes the disclosures required to be listed, such as those business associates of our office. This accounting will include the date of disclosure, the name of the entity or persons who receive the PHI.

Electronic notice - You have the right to receive a paper form of this notice of private policies from our office upon request if this notice was received electronically.

Rights to amend - You have the right to request our office amend the PHI. Our office, however, may deny such a request if we determine that the PHI was not created by our office, is not part of the designated record set, the information is not available for access to you, or the current information is accurate and complex. Amendment requests must be made in writing to our privacy director. Our office must act on such requests within 60 days of receipt of such requests. If we deny your request, we will inform you in writing within 60 days, indicating one of the reasons listed previously as the basis for denial. If you do not submit a statement if disagreement, you with any future disclosures of your PHI that is the subject of the amendment. If you submit a statement if disagreement (limited to 500 words), our office may prepare a written rebuttals to your statement. We will provide you with a copy of the rebuttal.

PATIENT'S RIGHTS

Our office is required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Our office is required to abide by the terms of the notice currently in effect. Our office reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain.

PATIENT'S RIGHTS

Patients may file a complaint with our office and with the Department of Health and Human Services Secretary if they believe their privacy rights have been violated. Complaints must be filed within 180 days of when you knew or should have known that the alleged violation occurred. To do so, please request a complaint from our privacy director. Please be assured, patients who file complaints will not be retaliated against for doing so.

CONTACT

For more information about our office's privacy policies, contact:

Privacy Director: Dr. Admasu Gizachew

Telephone: 609-879-0036

EFFECTIVE DATE

This notice for our practice is effective as of: 01/01/2023

NU DENTAL

178 STATE ROUTE 35 STE 6

EATONTOWN, NJ 07724

(732) 945-7999

(732) 945-7998

Patient Acknowledgement Form

I, _____, acknowledge that I have received and reviewed the Office privacy notice for Nu Dental.

Patient signature _____ Date_____

Guardian signature _____ Date _____

In case you do not agree to sign this form, our office must indicate why you declined to do so. This office will not refuse treatment to anyone based solely on the patients refusal to sign the acknowledgment.

Reason for refusal

_____

_____

_____

Privacy Director's signature

Dr. Admasu Gizachew

_____

_____

_____

NU Dental
178 State Route 35 Suite #6
Eatontown, NJ 07724
(732) 945-7999

Photo Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to NU Dental and AGN Dental, its affiliates and agents, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

(a) Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice;

(b) Permission to use my name; and

(c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given in perpetuity, and does not require prior approval by me.

Name: _____

Signature: _____

Address: _____

_____

Date: _____

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent
or Legal Guardian: _____ Print Name: _____

_____

The following is required if the consent form has to be read to the parent/legal guardian:
I certify that I have read this consent form in full to the parent/legal guardian whose signature appears above.

_____ _____

Date Signature of Organizational Representative or Community Leader

Revised/Updated: 10/8//2019