

**HIPAA Release form**

**Patient Name:**

\_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

\_\_\_\_\_  
Preferred Name

I authorize release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

spouse:

Child(ren):

Other:

Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing

\_\_\_\_\_  
Signature  
Date

\_\_\_\_\_  
Response Date:

Revocations must be written. Send them to the office contact person named at the beginning of the Notice.

#### YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment ( except emergency treatment), payment of healthcare operations. We do not have to agree to this, but if we agree, we must honor the restrictions that you want. We must honor restrictions not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask us to communicate with you in confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E mail address. We will accomodate these request if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communcations, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information with in 10 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of our health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and / or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list disclosures that we have made of your health information within the past six years ( or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment of health care opertalons; disclosures with yoy authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. you are entitled to one such list per year without change. If you want more frequent lists, you will have to pay for them in advance. we will usually respond to your request within 60 days of recleving it. But by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already.

If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of the Notice. Notified us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

#### OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by terms of this Notice of Privacy Pratices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we can change this Notice, the new privacy pratices will apply to your health information that we already have well as to such information that we may generate in the future. If we change our Notice of Privacy Pratices, we will post new noitce in our office, have copies available in our office, and post it on our Web site.

#### COMPLAINTS

If you think that we have not properly respected the privacy of yor health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If your prefer you can discuss your complaint in person or by phone.

#### FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Signature \_\_\_\_\_

Date \_\_\_\_\_

disclose information for treatment purposes are: setting up an appointment for you; examining your teeth, mouth and oral health; prescribing medications and faxing them to be filled; prescribing dental appliances; showing you treatment options; referring you to another dentist for specialty care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes, asking you about your dental or medical care plan, or other sources of payment; preparing or sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions for that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes within any special permission. If we need to disclose your health information outside of our office for these reasons?

#### USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandate that certain health information be reported for specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as or the license of doctors; for audits by Medicare or Medicaid, or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of court or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;

- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of 'limited data set' for research, public health, or health care operations;

incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

disclosures to 'business associates' who perform health care operations for us and who commit to respect the privacy of your health information.

#### APPOINTMENTS REMINDERS

We may call or write to remind you of schedule appointments, or that it is time to make routine appointment. We may also call or write to notify you of other treatment of services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder on your home answering machine or with someone who answers your phone when you are not home.

#### OTHER USES AND DISCLOSURES

We will make any other uses or disclosures of your health information unless you sign a written 'authorization form'. The content of an "Authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or Disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

## Notice Of Privacy Practices

### Geller Family Dental

850 Bronx River Road  
Bronxville, NY 10708  
914-776-1122 {Office}  
914-776-2410 {Fax}  
Gellerfamilydental@gmail.com

Patient Name:

\_\_\_\_\_ Last First MI

\_\_\_\_\_ Preferred Name

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

We respect our legal obligation to keep health information that identifies you private.  Yes  No

We are obligated by law to give you notice of privacy practices. This notice describes how we protect your health information and what rights you have regarding it. [ WE USUALLY WILL NOT ] ask you for special written permission.  Yes  No

#### TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information for treatment, payment or health care operations. Examples of how we use

[ We will ask for special written permission in the following situations: anything related to HIV/AIDS status, any sale information, any use of information for marketing or fundraising purposes, and

-uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; for the evaluation and health of members of the foreign service;

Patient Name:

\_\_\_\_\_ Last

\_\_\_\_\_ First

\_\_\_\_\_ MI

\_\_\_\_\_  
Preferred Name

**Our office policy**

**If this office accepts your insurance as full payment, there will only be an out-of-pocket expense for non-covered services, or if your yearly maximum has been reached. This is your responsibility.**

**If you have insurance whereby you have a co-payment per visit, this co-payment is required at time of service, unless prior arrangements have been approved.**

**If you do not have dental insurance, payment is required at time of service.**

**We work by appointment only. A charge will be made for any appointment broken without any advanced notice or any repeated last minute cancellations.**

**Your insurance does not cover broken appointments.**

**Financial Arrangements**

**Due to the highly specialized treatment that dentists provide, most treatment plans are usually complex. As a result of the amount of time that we invest in your treatment, along with material and overhead costs, payment is expected in full at the time of service unless other arrangements have been made in writing. For your convenience, we accept all major credit cards.**

**If you have dental insurance, we will contact your insurance company for you and determine as close as is possible what your portion is to pay on the date of service. This information is an estimate only and we cannot guarantee its accuracy. After your insurance company pays their portion, we will inform you of what balance, if any, is outstanding for you to pay. This amount will be due upon notification. Please note that your insurance policy is a contract between you and your insurance carrier. If for any reason your insurance carrier does not pay within forty-five days, as allowed by law, the balance will become your responsibility. In the unfortunate circumstance that your account becomes more than 90 days overdue, your account will be charged an additional collection fee of \$50.00.**

**Agreement**

**I understand the financial arrangements and agree with this payment schedule as a method of payment for my treatment. I understand that I am responsible for my total dental cost regardless of any insurance coverage.**

Patient

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Authorization**

**I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.**

**I authorize the insurance company indicated on this form to pay the dentist 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 the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Response Date: \_\_\_\_\_

**Insured's Birth Date:**

**ID #:**

**Group #:**

**Insured's Address:**

Address 1

Address 2

City

State

Zip Code

**Insured's Employer Name:**

**Employer Address:**

Address 1

Address 2

City

State

Zip Code

**Patient's relationship to Insured:**

Self  Spouse  Child  Other

**Insurance Plan Name:**

**Insurance Address:**

Address 1

Address 2

City

State

Zip Code

Please review and update your insurance information

Patient Name:

\_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Preferred Name

Primary insurance:

Name of Insured:

\_\_\_\_\_ Last

\_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Insured's Birth Date:

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address:

\_\_\_\_\_ Address 1  
\_\_\_\_\_ Address 2  
\_\_\_\_\_ City

\_\_\_\_\_ State \_\_\_\_\_ Zip Code

Insured's Employer Name:

\_\_\_\_\_

Employer Address:

\_\_\_\_\_ Address 1  
\_\_\_\_\_ Address 2  
\_\_\_\_\_ City

\_\_\_\_\_ State \_\_\_\_\_ Zip Code

Patient's relationship to insured:

Self  Spouse  Child  Other

Insurance Plan Name:

\_\_\_\_\_

Insurance Address:

\_\_\_\_\_ Address 1  
\_\_\_\_\_ Address 2  
\_\_\_\_\_ City

\_\_\_\_\_ State \_\_\_\_\_ Zip Code

Secondary insurance:

Name of Insured:

\_\_\_\_\_ Last

\_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Patient Name:

Last

First

MI

Preferred Name

Please list any other medical conditions not listed above:

Do you take any blood thinners? (Coumadin, Warfarin, Plavix, Aspirin, Aggrenox, Xarelto, Eliquis etc.)  
Please list all medications you are currently taking:

Do you have any Allergies?

Yes  No

If yes check all that apply:

- Aspirin
- Household Bleach
- Iodine
- Sulfas
- Seasonal/Environmental Allergies
- Metals
- Foods
- Dental Anesthetics
- Jewelry
- Penicillin/Amoxicillin
- Erythromycin
- Latex
- Tetracycline

Have you ever had an allergic reaction to Dental Anesthesia (Novocaine)?  
 Yes  No

If yes, what type of reaction and to what medication?

Joint Replacement: Do you have any artificial joints (hip, knee, elbow, shoulder, etc)?  
 Yes  No

Yes  No

Date of replacement surgery:

Yes  No

Were there any complications during surgery?

Yes  No

Have you ever taken, are currently taking, or scheduled to begin taking bisphosphonates for osteoporosis, hypercalcemia, multiple myeloma, metastatic cancer, skeletal complication resulting from Paget's disease, or bone pain? This includes Boniva, Alendronate (Fosamax), risedronate (Actonel), Aredia, and Zometa.  
Do you smoke or use tobacco?  
 Yes  No

Are you Pregnant? If yes, enter due date:

Yes  No

To the best of my knowledge the information I provided is accurate and complete:

Signature

Date



Check all that apply:

- Abnormal Bleeding
- Artificial Heart Valve
- Cancer - Chemotherapy
- Difficulty swallowing
- Gastric Bypass surgery
- Hepatitis
- In Good Health
- Mitral Valve Prolapse
- Respiratory Problems
- Stroke
- Weight Loss - Unexplained
- Alcohol Abuse
- Artificial Joints
- Circulatory Problems
- Drug Addiction
- Glaucoma
- Herpes
- Jaundice
- Osteoporosis
- Rheumatic fever
- Thyroid Problems
- No Medications
- Anemia
- Asthma
- Collis
- Epilepsy - Seizures
- Growth on Head or Neck
- High Blood Pressure
- Kidney Problems
- Pace Maker
- Scarlet Fever
- Tuberculosis
- Angina Pectoris
- Bisphosphonates
- Cosmetic Surgery
- Fainting spells / Dizziness
- Heart Problems
- High cholesterol
- Liver Disease
- Psychiatric Condition
- Sinus Problems
- Ulcers
- Arthritis
- Blood Transfusion
- Diabetic
- Fever Blisters
- Hemophilia
- HIV + /AIDS
- Low Blood Pressure
- Radiation Therapy
- Stents
- Venereal Disease

# Geller Family Dental

gellerfamilydental@gmail.com

gellerfamilydental.com

850 Bronx River Road • Bronxville, NY 10708

(914)776-1122

Chart#:

FOR OFFICE USE ONLY

Patient Name:

Last

First

MI

Preferred Name

Title:

Gender:

Male  Female

Mr/Ms/Mrs/etc

Family Status:

Married  Single  Child  Other

Birth Date:

SS#:

Prev. Visit:

Email Address:

Best time to call:

Phone:

Home

Mobile

Work

Ext

Fax

Other

Address:

Address 1

Address 2

City

State

Zip Code

Pharmacy name, address and telephone #:

Emergency contact name and telephone #:

Name and telephone number of your Physician, Cardiologist or any specialist:

Have you been hospitalized in the past (5) year? If so, for what?