Lawrence A. Kurzweil D.D.S, P.C.
General, Laser, & Implant Dentistry
251-04 80th Avenue
Bellerose, NY 11426
(718) 347-1348

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this i information can and will be used to

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the used and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing to you that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abider by such restrictions.

Patient Name:
_____

Signature:
_____

Date:
_____

Name:
_____
_
Address:_____
_____
Apt/Suite #:
_____
City: _____ State: _____
Zip:_____ Phone number: _____Which # is this?: Mobile Home Work
Sex (M/F):_____ Marital Status:_____Birthdate:
_____
Social Security #:_ _ _ - _ _ - _ _ _ _ Name of Policyholder:_____
Insurance Coverage (Y/N): _____ Employer Name:_____
Email:_____
_____
Referred by:
_____

Yes	No	Does your medical history include any of the following?
		1. Have you ever had a serious illness or operation?
		2. Are your under a physician's care? For what reason? _____
		3. When was your last complete physical exam? Date _____
		4. Are you taking medication?
		5. Do you have any allergies?
		6. Are you allergic to medications or substances?
		7. Are you allergic to penicillin, anesthetics, or antibiotics?
		8. Have you been treated for or told you have heart disease?
		9. Do you have a heart murmur?
		10. Do you have a pacemaker or artificial heart valve?

		11. Have you ever had rheumatic fever?
		12. Have you ever had surgery, radiation, or chemo for a tumor?
		13. Do you have high or low blood pressure?
		14. Do you have any inflammatory diseases, such as arthritis?
		15. Do you have any artificial joints or implants?
		16. Do you have any blood disorders?
		17. Have you ever bled excessively after being cut or injured?
		18. Do you have any kidney problems?
		19. Do you have any liver problems?
		20. Are you a diabetic?
		21. Do you have asthma?
		22. Do you have epilepsy or seizure disorders?
		23. Do you have or have you had venereal disease?
		24. Do you have AIDS?
		25. Have you ever had hepatitis?
		26. Do you or have you had TB?
		27. Do you smoke?
		28. Do you consume alcoholic beverages?
		29. Are you pregnant or suspect you might be?
		30. Do you have any disease, condition, or problem not listed?

What is your doctor's name and phone number?
Name:_____
Number:_____
List any drugs or medications you are presently taking:

In case of emergency, notify:_____ Ph #:_____

IF YOU DEFAULT ON YOUR OFFICE PAYMENT OR INSURANCE CO-PAYMENT WE MUST HIRE AN ATTORNEY TO GO TO COURT, YOU ARE RESPONSIBLE FOR ANY ATTORNEY FEES AND ANY COURT FEES.

_____ _____

Patient Guardian signature Date

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Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.
As required by HIPAA, we have prepared this explanation of how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be and internal quality assessment review.

We may also create and distribute de identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us at your first service delivery date
- The right to provide a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you or filing a complaint.

Please contact us if you would like more additional information:

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For more information about HIPAA:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(877) 696-6675