NEW PATIENT INFORMATION

NAME:_____**DOB**_____**SS#:**_____

ADDRESS:_____

EMAIL:_____

CELL #:_____**HOME#**_____

CURRENT DENTAL CONCERNS:_____

HOW DID YOU HEAR ABOUT US?:_____

NOTICE OF PRIVACY PRACTICES

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.
Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.
On Your Authorization: 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 uses 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.
To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters, emails.)
Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.
Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit: as required by law; for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury; to report adult abuse, neglect, or domestic violence; to health oversight agencies; in response to court and administrative orders and other lawful processes; to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person; to coroners, medical examiners, and funeral directors; to an organ procurement organizations; to avert a serious threat to health or safety; in connection with certain, research activities; to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities; to correctional institutions regarding inmates; and as authorized by state worker's compensation laws.

PATIENT RIGHTS

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may, but are not required to, 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 more information about fees.
Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates, disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us by using the information listed at the end of this notice for more information about fees.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means of 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 we should amend the information. We may deny your request under certain circumstances.

Signature_____**Date**_____

By signing, I authorize the office of Scott T. Gordon, D.D.S. to use all diagnostic aids deemed necessary to make a thorough diagnosis of the patient's dental needs. I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. I understand that a $35 fee will be assessed to my account for any appointment cancellations with less than 24 hours notice.

Signature_____**Date**_____

I acknowledge that I have received a Notice of Privacy Practices from the office Scott T. Gordon, D.D.S.