# PATIENT INFORMATION

Date_____

Name _____ Birthday _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____

Cell Phone # _____ E-mail _____

If Student, Name of School / College_____ City _____ Full or Part Time

Patient's or Parent's Employer_____

Person Responsible for this Account _____ Relationship to Patient _____

Person to Contact in Case of an Emergency _____ Phone _____

How Did You Hear About Our Office _____

## Insurance Information (If Applicable)

Name of Insured_____ Relationship to Patient _____

Name of Insured's Employer _____

Social Security # / Insured's I.D. # _____ Group # _____

Insurance Co. Name and Address_____

D.O.B. _____

**DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE:** _____

# PATIENT DENTAL HISTORY

Name of Previous Dentist and Location_____ Date of Last Exam/X-Rays _____

1. Do your gums bleed while brushing or flossing? ..... Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? ..... Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? ..... Yes No
4. Do you feel pain to any of your teeth? ..... Yes No
5. Do you have any sores or lumps in or near your mouth? ..... Yes No
6. Have you had any head, neck or jaw injuries? ..... Yes No
7. Have you ever experienced any of the following? ..... Yes No
   - Clicking? ..... Yes No
   - Pain (joint, ear, side of face)? ..... Yes No
   - Difficulty in opening or closing? ..... Yes No
   - Difficulty in chewing? ..... Yes No
8. Do you have frequent headaches? ..... Yes No
9. Do you clench or grind your teeth? ..... Yes No
10. Do you bite your lips or cheeks frequently? ..... Yes No
11. Have you ever had any difficult extractions in the past? ..... Yes No
12. Have you ever had any prolonged bleeding following extractions? ..... Yes No
13. Have you had any orthodontic treatment? ..... Yes No
14. Do you wear dentures or partials? ..... Yes No
    If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ..... Yes No
16. **Do you like your smile?** ..... Yes No
    If no, what would you like to change?
    _____


**Rowley Family Dental Center**
Douglas A. Shealy, D.D.S., PC
434 Haverhill Street, Rowley, MA 01969
978-948-2333

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | High Cholesterol ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Osteoporosis ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pacemaker ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| | | | Yellow Jaundice ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____


## Rowley Family Dental Center

Douglas A. Shealy, D.D.S., PC, 434 Haverhill Street, Rowley, MA 01969, 978-948-2333

## ***PATIENT CONSENT FORM EMAIL USE***

Patient Name / DOB: _____

Patient Address: _____

Patient Email Address: _____

Rowley Family Dental Center offers patients the opportunity to communicate with our organization and Providers by email. Transmitting patient information by email, however, has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

- Email can be circulated, intercepted, altered, forwarded, and stored in numerous paper and electronic files.
- Email can be immediately broadcast worldwide and be received by both intended and unintended recipients.
- Email senders can misaddress email.
- Emails are archived, stored and inspected through computer system audits.

## ***CONDITIONS FOR THE USE OF EMAIL***

We will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by our organization.

We will not use email communication for matters that maybe unlawful or contain sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, and issues of abuse, developmental disability, or substance abuse.

## ***INSTRUCTIONS***

To communicate by email, we will request that the patient shall:

- Limit or avoid use of his/her employer's computer.
- Inform us of any changes in his/her email address.
- Include his/her name in the body of the email.
- Include specific category in the email's subject line, for routing purposes (e.g., billing questions).
- Review the email to make sure it is clear, specific and contains relevant information before sending to our organization.
- Restricted communications from the patient must be provided if applicable.
- Withdraw email consent at anytime by email or written communication to our organization or Provider.

## PATIENT ACKNOWLEDGMENT AND AGREEMENT

### Email Use

I acknowledge that I have read and fully understand this email consent form. I understand the risks associated with the communication of email between the organization and my Provider, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the organization may impose to communicate with its patients by email. Any questions I may have had were answered.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

# OFFICE POLICIES

The Rowley Family Dental Center has been serving the community since 1985. Dr. Douglas Shealy is a member of the American Dental Association, the Massachusetts Dental Society and the North Shore District Dental Society. Dr. Shealy and his entire staff are committed to bringing you the best services dentistry has to offer, in the most comfortable way possible. However, to achieve this goal, we need your help!

**Health:** We ask that you answer the questions honestly and thoroughly on the health questionnaire and registration form. Please be aware that some medical conditions require that patients take antibiotic medication prior to each dental visit.

**Appointments:** We further ask that you keep your scheduled appointments. Although, we will make every attempt to confirm your appointments by telephone, we do charge a fee of $50.00 to patients who fail to appear for their appointments, or neglect to give us a 24-hour notice of cancellation.

**Insurance:** Many of our patients have some type of dental insurance, and as a service to these patients, we will process dental insurance claims. However, please be aware that insurance companies rarely pay the entire cost of a dental procedure and that the responsibility for payments ultimately falls upon the patient. There are many types of insurance plans available today, so if you have questions about your plan, please contact your insurance company directly. Payment is expected the day services are rendered, including insurance co-payments. We accept all major credit cards, and we currently offer a discount of 5% to patient's age 65 and older.

**Minors:** Our younger patients (under age 18) need to be accompanied by a parent designated as the 'responsible party'. No treatment can be rendered without permission from the 'responsible party'. In accordance with recent federal guidelines regarding privacy, no patient records will be released to a third party without written permission from the patient or guardian. Likewise, we will protect any information released for the purpose of processing insurance claims.

Rowley Family Dental Center is fully handicap accessible and the entire staff is CPR certified. Nitrous oxide anesthesia is available upon request. Also, in order to do a complete evaluation, a set of x-rays will be necessary. If you have any special requirements, please feel free to speak with one of our well-trained staff members.

We sincerely hope you will continue to have a satisfying dental care experience at our office.

Please sign and date that you have read and understand the above policies.

Name (print) _____

Name (signature) _____ Date: _____

2/11

**Rowley Family Dental Center**
Douglas A. Shealy, D.D.S., PC
434 Haverhill Street, Rowley, MA 01969
978-948-2333

# 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

Dr. Douglas A. Shealy is required by applicable federal and state law to maintain the privacy of your health information. He is also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. Dr. Shealy must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect today, 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to an orthodontistist, periodontist, endodontist, oral surgeon, orthopedic surgeon, cardiologist, primary care physician, pharmacist or any other healthcare provider providing treatment to you. Also, if any laboratory services are required your information may be used to identify your case.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you through your dental insurance carrier.

**Your Authorization:** You may give Dr. Shealy 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**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 if there is an emergency. 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 incapacity or 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.

**Marketing Health-Related Services:** We will not use your health information for marketing communications.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

**Appointment Reminders:** Dr. Shealy and his staff, may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). This reminder may also include reference to any medications needed prior to treatment.

**Rowley Family Dental Center**
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# PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time.

**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).

**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.)

**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.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us. We support your right to the privacy of your health information.

**Contact Officer:** Douglas A. Shealy, D.D.S., PC

**Address:** 434 Haverhill Street, Rowley, Ma. 01969

**Telephone:** (978)948-2333


**Rowley Family Dental Center**

Douglas A. Shealy, D.D.S., PC
434 Haverhill Street, Rowley, MA 01969
978-948-2333

# NOTICE OF PRIVACY PRACTICES

**Purpose**: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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**Rowley Family Dental Center**
Douglas A. Shealy, D.D.S., PC
434 Haverhill Street, Rowley, MA 01969
978-948-2333

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**✍ You may refuse to sign this acknowledgement ✍**

I, (your name)_____, have received a copy of this office's Notice of Privacy Practices.

❑ Yes, I consent to the transfer of X-Rays to other Doctors if necessary.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

---

**For Office Use Only**

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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)

_____

_____

_____

**Rowley Family Dental Center**
Douglas A. Shealy, D.D.S., PC
434 Haverhill Street, Rowley, MA 01969
978-948-2333

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.

*If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.*

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing-related information. This information is considered protected health information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

**Our Responsibilities**

Rowley Family Dental is required to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information that we collect and maintain.

We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain.

Copies of our Notice are available in our main reception area(s) and on our website.

**How We May Use and Disclose Medical Information About You.**

The following describes examples of the way we may use and disclose medical information:

**For Treatment**: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care.

We may communicate your information using various methods, orally, written, facsimile and electronic communications.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/ treatment plan and diagnosis.

**For Payment:** We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. Examples may include contacting your insurance company for referrals, verification or preapproval of covered services.

**For Health Care Operations**: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. We may contact you to remind you of your appointment by telephone or reminder card unless requested otherwise.

**Business Associates, BA**: Provide services for our organization through written contracts and/or service agreements. Examples of these services include billing and collection and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third-party payer for services rendered. The BA is also required by law to protect and safeguard your health information which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

**Breach Notification:** In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within 60 days of the breach. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

**Uses and Disclosures That May Be Made *With* Your Consent, Authorization or Opportunity to Object**

We will not use and disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for, most uses and disclosures of psychotherapy notes; PHI for marketing purposes unless we speak with you and disclosures that constitute a sale of PHI. If you provide an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

**Individuals Involved in Your Care or Payment for Your Care:** Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Future Communications:** We may communicate with you via newsletters, mailings, or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to ***opt out*** at any time ***if you are not or no longer interested in receiving these communications or methods of communications.*** Please contact our Privacy Officer. Marketing and Fundraising initiatives, if applicable are limited and may require a separate authorization.

**Uses and Disclosures That May Be Made *Without* Your Authorization or Opportunity to Object**

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

**As required by law**: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

**Law Enforcement/Legal Proceedings**: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

**State-Specific Requirements**: Many states have reporting requirements which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

**Your Health Information Rights Patients Rights**

Although your health record is the physical property of the practice that compiled it, you have the right to:

**Inspect and Copy**: You and/or your personal representative have the right to inspect, review and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or a review must be submitted in writing to Rowley Family Dental. There will be a fee charged for all applicable copying and producing copy of portable media (CD, USB) up to the maximum amount as prescribed by governing law.

**Amend**: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.

**An Accounting of Disclosures**: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment and health care operations. Rowley Family Dental will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

**Request Restrictions**: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or health care operations. *Restrictions from your health plan (insurance company)*: You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

*Other Restrictions, Limiting Information:* You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.

We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

**Request Confidential Communications**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or address or deny communication through texting or email.. We ask that you submit these requests in writing.

Email and texting communication requests if applicable may require a separate authorization from you. To exercise any of your rights, please submit your request in writing to the practice's privacy officer indicated below.

**For More Information or to Report a Problem**

If you have questions and would like additional information please contact the Privacy Officer. If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services at 800-368-1019. Further instructions for filing a complaint can also be found at www.hhs.gov/ocr. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred and there will be no retaliation for filing a complaint.

Telephone Number: **978-948 -2333**

**Privacy Officer:** BreeAnn White
**Security Officer:** Douglas Shealey

# Rowley Family Dental


**434 Haverhill Street**
**Rowley, MA 01969**

**Phone: 978-948-2333**
**Fax: 978-948-3752**
*www.**rowleyfamilydental.com***


# NOTICE OF PRIVACY PRACTICES

## Health Insurance Portability and Accountability Act of 1996 (2001, 2003 and 2013)

Previously Modified
Sept 10, 2014
May 31 2017
July 10, 2018

**Last Modified**
**September 10, 2020**

*Prepared by Linda Doherty Associates and HARLLC. Given the complexity of the HIPAA Privacy, Security and HITECH laws this information is prepared as required with the understanding that LDA and HAR LLC are not engaged in rendering legal services nor advice.*

**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 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

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).

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.

4. **Permission**
   I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

_____ _____

**Patient Signature** **Date**