

**Lee Zhao, DMD, PC**  
2055 Beaver Ruin Rd., Suite E  
Norcross, GA, 30071  
Telephone: (770) 242-0021

## NOTICE OF PRIVACY PRACTICE

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law 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 law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

**Unless you request otherwise**, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. 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 certain rights in regards to your health information**, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below.

- The right to request restrictions on certain uses and disclosures of protected health information, including these related to disclosures to family members, other relatives, close personal friends, or any other person identified to 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 request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

**We are required by law to maintain the privacy of your protected health information** and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

**This notice is effective as of \_\_\_\_\_, 20\_\_\_\_**, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

**You have the right to formal, written complaint** with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

**For more information about our Privacy Practices, please contact:**

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2055 Beaver Ruin Rd., Suite E  
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**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Ave. , S.W.

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## ACKNOWLEDGEMENT OF PRIVACY PRACTICE

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason or reasons:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

**THANK YOU FOR YOUR VISIT!**

**Monday: 9AM - 6 PM**  
**Tuesday: 8 AM - 5 PM**  
**Wednesday: 8AM - 5PM**

**Thursday: 10AM - 7PM**  
**Friday: CLOSED**  
**Saturday: 9AM - 3PM**

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**PATIENT  
 INFORMATION**

**PATIENT INFORMATION**

PATIENT FIRST NAME:		MI:	PATIENT LAST NAME:		PATIENT SOCIAL SECURITY NO.:		TODAY'S DATE:	
							MM DD YYYY	
ADDRESS:				CITY:	STATE/ZIP CODE:	DRIVER'S LICENSE NO.:		
HOME PHONE:		WORK PHONE:		CELLULAR PHONE:	E-MAIL:			
					<input type="checkbox"/> I would like to receive correspondence via e-mail			
DATE OF BIRTH:		AGE:	GENDER:		MARITAL STATUS:			
MM DD YYYY			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
EMPLOYMENT/STUDENT STATUS:				PERSON FINANCIALLY RESPONSIBLE FOR SERVICES:				
STUDENT: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time EMPLOYMENT: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired				<input type="checkbox"/> Patient is the responsible party for payment for dental services <input type="checkbox"/> Patient is a policy-holder of responsible party				

**CONTACT IN CASE OF EMERGENCY**

NAME:	HOME PHONE:	WORK OR CELL PHONE:	RELATIONSHIP:

**RESPONSIBLE PARTY**

(Please complete only if responsible party is someone other than the patient)

FIRST NAME:		MI	LAST NAME:		SOCIAL SECURITY NO.:		DATE OF BIRTH:	
							MM DD YYYY	
ADDRESS:				CITY:	STATE/ZIP CODE:	DRIVER'S LICENSE NO.:		
HOME PHONE:		WORK PHONE:		CELLULAR PHONE:	RELATIONSHIP TO PATIENT:			

**DENTAL INSURANCE INFORMATION**

PRIMARY INSURANCE				SECONDARY INSURANCE			
NAME OF INSURED:		RELATIONSHIP TO PATIENT:		NAME OF INSURED:		RELATIONSHIP TO PATIENT:	
SOCIAL SECURITY NO.:		DATE OF BIRTH:		SOCIAL SECURITY NO.:		DATE OF BIRTH:	
		MM DD YYYY				MM DD YYYY	
EMPLOYER:		INSURANCE COMPANY:		EMPLOYER:		INSURANCE COMPANY:	
ADDRESS:				ADDRESS:			
CITY:		STATE/ZIP:		CITY:		STATE/ZIP:	
EMPLOYER PHONE:	EMPLOYER ID:	GROUP#:	EMPLOYER PHONE:	EMPLOYER ID:	GROUP#:	EMPLOYER PHONE:	EMPLOYER ID:

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*Where your smile counts***PATIENT  
MEDICAL HISTORY****PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_**PLACE A MARK ON "Yes" OR "No" TO INDICATE ANY OF THE FOLLOWING:**

Are you under the care of a physician?

 No  Yes

If yes, please explain: \_\_\_\_\_

Do you have any general health problems?

 No  Yes

If yes, please list: \_\_\_\_\_

Are you currently taking any drugs or medications?

 No  Yes

If yes, please list: \_\_\_\_\_

Are you allergic to any medications?

 No  Yes

If yes, please list: \_\_\_\_\_

What is the name of your pharmacy? \_\_\_\_\_

**PLACE A MARK ON "Yes" OR "No" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:**

	No	Yes		No	Yes		No	Yes
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problem	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Abnormally, after extractions or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis - Type:( )	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problem	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Feet or Ankle	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Growth on Head or Neck	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Women:</b> Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Weight Loss?	<input type="checkbox"/>	<input type="checkbox"/>
			Date Due? _____					
			Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>			

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: \_\_\_\_\_

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## FINANCIAL AND CANCELLATION POLICIES

**PATIENT NAME:** \_\_\_\_\_

### 1. FINANCIAL OBLIGATIONS:

The financial obligation for dental treatment is between you and this office and is not dependent upon insurance coverage. Payment for dental services is due at the time treatment and services are rendered. Our professional services are rendered to the patient, not to the insurance company. Therefore, the patient is responsible for the full fee regardless what the insurer pays.

### 2. PAYMENT OPTIONS:

Specific payment options will be discussed on an individual basis. Payment options may include cash installments based on your treatment plan, third party financing, and insurance coverage. We accept cash, personal checks, and most major credit cards including VISA, MasterCard, and American Express.

### 3. INSURANCE FILING:

As a courtesy to our patients, we will complete and file any insurance form. Your insurance company will then variably reimburse you directly for any covered dental procedures.

### 4. APPOINTMENT CANCELLATION POLICY:

We try very hard to keep to our schedule for our patients, and hope our patients try as well. Since we would reserve a place for you and other patients on the day and time of your appointment, we ask you to please give us at least 48 hours advanced notice if you are unable to keep your appointment. Only in this manner are we able to provide the optimum treatment our patients demand and deserve.

**NOTE:** *Courtesy reminders are sent out via email and/or through text messaging one week prior to your appointment. Please secure your reservation by responding to our reminders. All appointments not secured by 12:00 noon the day before will need to be rescheduled.*

*We understand there are emergencies. However, a charge of \$50.00 or 10% of your appointment fee, whichever is greater, will be assessed if you fail to give us 24 hours notice that you will be unable to keep your appointment.*

Our staff has made a promise, professionally and personally, to give you the concern, respect and care that makes our office a comfortable and pleasant place to visit. We ask that you give us enough warning if you are unable to keep your scheduled appointment so that we can treat another patient.

### 5. DELINQUENT ACCOUNTS:

If your account becomes delinquent and is turned over to a collection agency, additional finance charges may be applied to your account

**I am aware and accept my financial obligations and agree with the financial and cancellation policies above mentioned.**

Signature: \_\_\_\_\_

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

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