

**Scott L. Goldstein, DDS
Pediatric Dentistry of Long Island, PC
1719C North Ocean Avenue
Medford, NY 11763
631.654.4242**

Dear Parents,

We would like to take the time to thank you for selecting our office to take care of your child's oral health. We look forward to helping your child have a great smile and stay in great oral health!

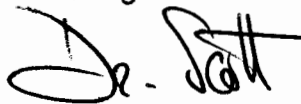
Now that you have arranged for your child's visit to our office, there may be some questions that you would like to ask us. The most common question is "How can I best prepare my child for his/her visit?" Try to be relaxed and at ease yourself. Your child will sense any anxiety or nervousness on your part. Tell your child that we will count, brush and clean his/her teeth. We may take special "pictures" of their teeth called "x-rays". We may place "tooth vitamins" on their teeth to make them grow healthy and strong. Please do not use any fear provoking words such as "hurt", "pull", "drill", and especially, "needle." Avoid and statements such as "the doctor will not hurt you" or "it will only hurt a little bit." (If I said to you, "Do not think of a big gray elephant" – what is the first thing you think of? The ELEPHANT! It is the same thing with the word "hurt.")

We will thoroughly explain each of our procedures to your child in terms that he/she can understand before we proceed. Be assured that we will treat your child as tenderly and with as much compassion as we would want our own family members to be treated. However, in spite of the best intentions, some children will cry. This is a perfectly normal response to a new situation.

At the first visit, we will emphasize oral health techniques to be practiced by you and your child. A full examination of the teeth and the supporting structures will be done and the child's occlusion (bite) will be evaluated. Radiographs (x-rays) may be taken if necessary to see those structures and potential problem that are not visible to the bare eye itself and assure a thorough and comprehensive examination. Our emphasis is on "prevention" both in the office and at home. We recommend regular and periodic examinations and cleanings as well as positive and thorough home care. Because the primary teeth form the basis of the adult dentition, we will do everything to preserve the integrity of your child's dentition while fostering a healthy and relaxed attitude toward dental care.

Please be aware that we require a parent or legal guardian at all appointments to facilitate communication and dental care. We are always happy to answer your individual questions at ANY time. Your aim as a parent is the same as our aim in this office: To keep your child's teeth, mouth, and smile in great oral health and to make this process as pleasant and easy for everyone!

Yours in great oral health,



Scott L. Goldstein, DDS
Pediatric Dentistry of Long Island, PC
1719C North Ocean Avenue
Medford, NY 11763
631.654.4242
631.654.4291 fax

This mini dictionary is provided to our parents to explain some of the terms that are unique in our pediatric dental practice. It is our hope that these terms will help to reduce any anxiety that the children (and their parents!) may have about their dental visit. This is just one more way we try to make the children feel more comfortable in the practice!

OFFICE TERM

Camera
Picture
Sleepy juice
Tooth pillow
Tooth jelly
Tooth counter
Mr. Thirsty or straw
Vacuum cleaner
Ballerina toothbrush
Fire engine
Motorcycle
Toothpaste
Vitamins
Bunny tails
Tooth shampoo, tooth soap
Flashlight
Tooth ring
Raincoat
Sweet air
Astronaut nose
Silver star
White star
Tooth glue
Cap, tooth hat
Water squirter
Tooth paint

ACTUAL TERM

X-ray machine
X-ray film
Local anesthesia (numbing injection)
Mouth prop
Topical anesthesia
Dental explorer (used for detecting cavities)
Saliva ejector
High speed suction
Prophy brush
Handpiece (drill) with water
Handpiece without water
Prophy paste
Topical fluoride
Cotton balls
Etchant (used before bonding procedures)
Light curing unit (for bonding procedures)
Rubber dam clamp (holds rubber dam still)
Rubber dam (isolates tooth to keep it dry)
Nitrous oxide (laughing gas for relaxation)
Nosepiece for nitrous oxide
Amalgam (silver) filling
Composite (white) filling
Dental cement or bonding agent
Crown (to cover decayed/broken tooth)
Air/Water syringe (cools and cleans tooth)
Sealants

We NEVER use the words: PAIN, HURT, GAG, or VOMIT!

We NEVER use the words: PAIN, HURT, GAG, or VOMIT!

Child Health/Dental History Form

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>					
Phone <small>Home Work</small>			Sex M <input type="checkbox"/> F <input type="checkbox"/>		
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.					
Has the child had any history of, or conditions related to, any of the following:					
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
Please list the name and phone number of the child's physician:					
Name of Physician _____			Phone _____		

Child's History

		Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2.	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3.	<input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____			
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?	6.	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7.	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?	8.	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?.....	9.	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?.....	10.	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?.....	11.	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?.....	12.	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?	13.	<input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?	14.	<input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15.	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?	16.	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed?	17.	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18.	<input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?	19.	<input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?	20.	<input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water			
22. Does the child take fluoride supplements?	22.	<input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?	23.	<input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24.	<input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?.....	25.	<input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____			
27. Does child participate in active recreational activities?	27.	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist Comments _____ _____ _____ _____

For Office Use Only: Medical Alert Premedication Allergies Anesthesia Reviewed by _____

Date _____

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

BACK BILL NO NETWORK: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Scott L. Goldstein, DDS
Pediatric Dentistry of Long Island, PC
1719C North Ocean Avenue
Medford, NY 11763

CONSENT TO TREATMENT

Patient's Name: _____

Address: _____

City/State/Zip code: _____

I hereby grant authority to:

Scott L. Goldstein, DDS
Pediatric Dentistry of Long Island, PC
1719C North Ocean Avenue
Medford, NY 11763

and/or to the doctor(s) in charge of the care of the patient whose name appears above to administer any treatment, or dental treatment as it may be deemed necessary or advisable in the diagnosis and treatment of this patient.

I also authorize Pediatric Dentistry of Long Island, PC/Scott L. Goldstein, DDS and its associates to release any information pertinent to my case, in the course of my examination or treatment to insurance companies, adjusters, or attorneys if applicable.

Parent or Guardian: _____

Signature: _____

Relationship: _____

Scott L. Goldstein, DDS
Pediatric Dentistry of Long Island, PC
1719C North Ocean Avenue
Medford, NY 11763

FINANCIAL INFORMATION POLICY

Our office is dedicated to providing the highest quality oral health care for your children. We believe that that best oral health care is based on a friendly and mutual understanding between the doctor, staff and families we are privileged to serve.

PAYMENT

Please be aware that the parent/guardian that is bringing the child to the office is responsible for payment of all professional fees. We expect payment at the end of each visit. For your convenience, we take Visa, MasterCard, American Express, personal check, and cash. If we take your insurance, you are responsible for any co-payments before you leave the office. If we do not take your insurance and your insurance allows you to go out of network, we can accept the part the insurance company will pay however, you will be responsible for paying the difference before you leave the office. Any bills not paid by the insurance company in 30 days will be sent to you for immediate payment. Three (3) missed, broken, or last minute cancellations will result in dismissal from the practice.

Please check method of payment:

Insurance/
Co-payments Visa American
Express MasterCard Check Cash

CANCELLATIONS

Unfortunately, emergencies come upon everyone's life and take immediate priority over regular scheduled plans. However, we ask you to let us know 48 hours in advance if you must cancel, schedule or miss an appointment so we may schedule another child in need of dental care in a timely fashion. Not doing so will result in a \$50 charge for the missed or broken appointment.

DENTAL INSURANCE

All insurance policies are a contract solely between you, the responsible party and the insurance carrier. If you have any questions regarding your insurance plan, please call your insurance company to better explain the specifics and any details of your plan that you have concerns over. We encourage all parents to call their insurance company and have them explain your benefits.

I, the parent/guardian understand the financial policy of Pediatric Dentistry of Long Island, PC and agree to abide by them. If I have insurance, I request payment of authorized benefits to be made to Pediatric Dentistry of Long Island, PC for services rendered to my by the provider. I have read and agree to the above.

Name of parent/guardian _____

Permanent Signature on File _____ Date _____

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. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

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.

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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. 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. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 death. 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 without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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 obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0._____ for each page, \$_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will 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 a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

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.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or 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 the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Consent for Use and Disclosure of Health Information

USE OF THIS FORM IS OPTIONAL

Purpose: In cases where _____ has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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

Please Print Name

Signature

Date

For Office Use Only

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)

