Krugman Dental Associates, LLC

Gary J. Krugman, DMD
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ 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. 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 our office at 973-992-4099 or by mailing us at 154 South Livingston Avenue, Suite 107, Livingston, NJ 07039.

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 address above. Please understand that revocation of this Consent will not affect any action we took 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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Krugman Dental Associates, LLC

FINANCIAL MENU

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you, regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options and welcome your suggestions and questions.

A) Split Payment

Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

B) Pre-Authorized Credit Card Agreement

With your permission and signature, we will charge your Visa, MasterCard, American Express, or Discover with an agreed payment amount each month. This allows you to make monthly payments without applying for additional credit.

C) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

D) Prepayment in Full (For treatment over $2000)

A prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

E) Dental Fee Plan

With fast approval over the phone from Dental Fee Plan, your payment can be much lower than those available through our office. Dental Fee Plan specializes exclusively in helping patients with larger dental cases to receive the treatment they want. Dental Fee Plan carries fixed rates and can extend terms out to 60 months. There is no prepayment penalty. We will assist you in contacting them from our office.

F) **Gradual Treatment Plan**

FOR THOSE PATIENTS ON A LIMITED BUDGET. By prioritizing treatment, those patients who do not have dental insurance or on a tight budget can still complete their dental work by spreading appointments over several months or years.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks, or Dental Fee Plan (see above).

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

I certify that I have read, fully understand, and accept the above financial policy.

Signature: _____ Date: _____

154 South Livingston Avenue, Suite 107 • Livingston, NJ 07039 • (973) 992-4099

www.LivingstonSmiles.com

Krugman Dental Associates, LLC

MEDICAL HISTORY

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 that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ Name of physician _____
Physician's Address _____ Telephone Number _____ Date of Last Physical _____
Are you now under care of a physician? Yes ❑ No ❑
Are you pregnant or think you may be pregnant? Yes ❑ No ❑ If yes, expected delivery date: _____
Are you nursing? Yes ❑ No ❑
Are you taking birth control pills? Yes ❑ No ❑
Do you smoke? Yes ❑ No ❑ If yes, how much? _____
Are you taking any medication now? Yes ❑ No ❑ If yes, names of medications and problems for which they are taken:
Medication 1) _____ Taken for _____ 3) _____ Taken For _____
2) _____ Taken for _____ 4) _____ Taken For _____

Do you use tobacco? ..... Yes ❑ No ❑
Have you ever required a blood transfusion? .... Yes ❑ No ❑
Do you or have you used controlled substances? Yes ❑ No ❑
Have you ever taken Fen-Phen or Redux? Yes ❑ No ❑
Are you wearing contact lenses? ..... Yes ❑ No ❑
Do you bruise easily? ..... Yes ❑ No ❑

Have you ever had (please check-mark appropriate boxes):

Heart disease ..... Yes ❑ No ❑
Rheumatic fever ..... Yes ❑ No ❑
Abnormal blood pressure ..... High ❑ Low ❑ No ❑
Ulcers ..... Yes ❑ No ❑
Tuberculosis or lung disease ..... Yes ❑ No ❑
Diabetes ..... Yes ❑ No ❑
Epilepsy ..... Yes ❑ No ❑
Anemia ..... Yes ❑ No ❑
Congenital heart lesions ..... Yes ❑ No ❑
Arthritis ..... Yes ❑ No ❑
Lymph node enlargement (swollen glands) ..... Yes ❑ No ❑
Common cold ..... Yes ❑ No ❑
Kidney trouble ..... Yes ❑ No ❑
Prolonged bleeding ..... Yes ❑ No ❑
Excessive urination and/or thirst ..... Yes ❑ No ❑
Sexually Transmitted Disease ..... Yes ❑ No ❑
Epilepsy/Seizures ..... Yes ❑ No ❑
Mental Health Care ..... Yes ❑ No ❑
Back problems ..... Yes ❑ No ❑
Chemical dependency ..... Yes ❑ No ❑
Cold sores/Fever blisters ..... Yes ❑ No ❑
Eating disorders ..... Yes ❑ No ❑

Cancer ..... Yes ❑ No ❑
Mitral valve prolapse ..... Yes ❑ No ❑
Night sweats ..... Yes ❑ No ❑
Heart murmur ..... Yes ❑ No ❑
Jaundice ..... Yes ❑ No ❑
Drastic weight loss ..... Yes ❑ No ❑
Asthma or hay fever ..... Yes ❑ No ❑
Sinus trouble ..... Yes ❑ No ❑
Hepatitis ..... Yes ❑ No ❑
X-ray treatments for cancer ..... Yes ❑ No ❑
Glaucoma ..... Yes ❑ No ❑
Persistent diarrhea ..... Yes ❑ No ❑
Stroke ..... Yes ❑ No ❑
Fainting spells ..... Yes ❑ No ❑
Swollen ankles ..... Yes ❑ No ❑
Pacemaker ..... Yes ❑ No ❑
Heart surgery ..... Yes ❑ No ❑
AIDS/HIV ..... Yes ❑ No ❑
Thyroid problem ..... Yes ❑ No ❑
Allergies ..... Yes ❑ No ❑
Joint replacement or implant ..... Yes ❑ No ❑

If you have entered "yes" to any of the above, please explain: _____

Are you allergic to or have you had reactions to:

Local anesthetics like novocaine ..... Yes ❑ No ❑
Penicillin or other antibiotics ..... Yes ❑ No ❑
Sulfa drugs ..... Yes ❑ No ❑
Barbiturates, sedatives, or sleeping pills ..... Yes ❑ No ❑

Aspirin ..... Yes ❑ No ❑
Iodine ..... Yes ❑ No ❑
Any metal (e.g. gold, nickel, etc) ..... Yes ❑ No ❑
Latex/Rubber ..... Yes ❑ No ❑

Other (please list) _____

*Your signature indicates you have received a copy of the HIPPA law and Dental Materials forms and release Dr. Krugman to utilize any dental photographs for lecturing and educational purposes.

Signature: _____ Date: _____

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____
What is your primary concern that you would like us to address first? _____
When would you like us to start treatment? _____
Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?……Yes ❑ No ❑
If so, explain: _____
What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

Do you have missing teeth?_____ If yes, have you had them replaced?_____
If you have had missing teeth replaced, are you happy with the results? _____
If not, would you like to learn about your options to replace them? _____
Do you ever feel (or have you ever been told) that you don't have fresh breath? _____
How often do you brush your teeth?_____ How often do you floss?_____ What type of brush do you use? Manual ❑ Powered ❑
Do you avoid brushing any part of your mouth because of pain? Yes ❑ No ❑ If yes, what part? _____
Which foods cause you twinges of pain: hot ❑ cold ❑ sweet ❑ sour ❑ none ❑ Do you lose fillings or break fillings?……..Yes ❑ No ❑
Do you chew on only one side of your mouth?……Yes ❑ No ❑ If yes, explain: _____
Do your gums feel tender or swollen?……..Yes ❑ No ❑ Do you usually have many cavities?…….Yes ❑ No ❑
Do you clench or grind your jaws while sleeping or during the day?……Yes ❑ No ❑ Do your jaws ever feel tired?……..Yes ❑ No ❑

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

❑ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
❑ Spreading payments out over time may help me to achieve the excellent results I desire.
❑ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
❑ I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
❑ Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/ emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)_____
Would you like to have whiter teeth? ❑ Yes ❑ No
If you had a magic wand, what, if anything, would you change about your smile?_____
What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____
Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight… Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes ❑ No ❑. If yes, please check off all that apply:

❑ Lighten all front teeth showing	❑ Rebuild fracture(s)	❑ Straighten rotation	❑ Eliminate dark or stained fillings
❑ Lighten single tooth	❑ Lengthen	❑ Straighten angulation	❑ Reduce gum showing in smile
❑ Close spaces between teeth	❑ Shorten	❑ Eliminate crowding	❑ Repair uneven edges

Please add anything you feel is important: _____

At Krugman Dental Associates, LLC, though our focus is on appearance-related dentistry, our team also delivers routine general dental care as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Warm regards,
Gary J. Krugman, DMD

Krugman Dental Associates, LLC

PATIENT REGISTRATION

Date: _____

Welcome to Krugman Dental Associates, LLC. Would you please be kind enough to answer the following questions? Thank you so much for being our guest!

Name (Last) (First) (Middle) Date of Birth Sex (M F) Marital Status (S M D W) Social Security Number

How would you like to be addressed? Email Address Cell Phone Number

Home Address (Street) (City) (State) (Zip Code) Home Phone Number

Name of Employer Occupation Driver's License Number

Business Address (Street) (City) (State) (Zip Code) Business Phone Number

Person Responsible for Account

Who is responsible for account? self spouse parent/guardian other
(Please fill in the following information if the person responsible is different than self.)

Name (Last) (First) (Middle) Social Security Number

Home Address (Street) (City) (State) (Zip Code) Home Phone Number

Name of Employer Occupation Business Phone Number

Insurance Information

Insured Member (Last) (First) (Middle) Relationship SSN Date of Birth

Name of Employer Occupation Business Phone Number

Business Address (Street) (City) (State) (Zip Code) Dental Insurance Co.

Group Number _____ ID Number _____

What are your hobbies? Special interests? _____

How did you hear of Dr. Krugman? _____

If patient was assisted with this form,
Enter name of person assisting: Patient:

Print name Sign name Date Sign name* Date

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NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE 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) 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 are required to maintain the privacy of your health information and 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* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *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 an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual 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—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

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.

This notice is effective as of April 2003 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our 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 their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Krugman Dental Associates, LLC
154 South Livingston Avenue, Suite 107
Livingston, NJ 07039
973-992-4099
www.LivingstonSmiles.com

For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257
Toll Free: 1-877-696-6775