Margarita Jaber, D.D.S.

General, Cosmetic Dentistry & Implants

Dr. Margarita Jaber

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:

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.

REVOCATION 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: _____

DENTAL HEALTH HISTORY
(Confidential)

Reason for Today's Visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____
Check (✓) if you have had problems with any of the following

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sore or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?"These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give an approximate date _____
(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever

Medications

List Medications you are currently taking:
_____
_____
_____
Pharmacy name _____
Phone(___)_____

Allergies

- ☐ Aspirin
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Latex
- ☐ Other _____

Signature

The above information is accurate and complete to the best of my knowledge. 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 _____ Date _____

Dr. Margarita Jaber
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO INFORMS YOU OF HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE READ 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 this office in any form, whether electronically, on paper or orally, are kept properly confidential. This act gives you, the patient, new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse 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**: Providing, coordinating or managing health care and related services by one or more health care providers. EXAMPLE: teeth cleaning services.
- **PAYMENT**: Activities such as obtaining verifiable information for the purpose of filing claims for re-imbursement of payment for services rendered. Billing and collection activities and utilization review. EXAMPLE: filing a claim with your insurance company for payment.
- **HEALTH CARE OPERATIONS**: This includes the business aspects of running the practice, such as conducting assessment and improvement activities; auditing functions, cost management analysis and customer service. EXAMPLE: Internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related services that may be of interest to you.

Any other use or 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 use 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 request to receive confidential communications of protected health information from us by alternate means or at alternate locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive a simplified account of disclosures of protected health information.
- The right to obtain a copy of this notice from us upon request.

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 with respect to protected health information.

This notice is effective as of **April 14, 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 your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Margarita Jaber, D.D.S

1712 Eye Street, N. W. Suite 906

Washington, D.C. 20006

202-496-0891

dr@daisydentaldc.com

More information about HIPPA:

U.S. Department of Health & Human Services – Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

Toll free: 1-877-696-6775

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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)

_____

_____

_____

Margarita Jaber, D.D.S.
1712 I Street NW Suite 906
Washington, DC 20006

PAYMENT POLICY:

1. Payment is expected at the time treatment is rendered.
2. Cash and credit cards such as Visa, Master Card, American Express, Discover and Diners Club cards are welcome.
3. Personal checks and money orders with proper identification are welcome.

APPOINTMENT POLICY:

1. Please be on time.
2. A $50.00 fee will be assessed for any broken appointment or any appointment cancelled without 24 hour notice.
3. Two (2) consecutive broken appointments or last minute cancellations can result in the inability to accommodate your schedule.

INSURANCE PLANS:

1. You are responsible for your co-payment and your yearly deductible at each visit.
2. We accept assignment of insurance payments, but you are ultimately responsible for any charges the insurance company does not pay.

FINANCE CHARGES:

All accounts unpaid for over 60 days are subject to an additional administrative fee and or possible collections activity.

I certify that I have read the above policy statement, understand it and will follow the provisions as stated.

_____ _____

Patient, Parent or Guardian Signature Date

Office Policies

Payment Policy:

- Payment is expected by the time treatment is rendered. We do not bill patients.
- Cash and credit cards such as: Visa, MasterCard, American Express, Discover.
- A personal check with proper identification is welcome.
- Care Credit and the Lending Club are also accepted.

Appointment Policy:

- Please be on time! Arriving 15 minutes after appointment time will result in a cancellation.
- **A $50 fee will be assessed for any broken/canceled appointment without a 24 hour notice.**
- Two (2) consecutive broken appointments or last minute cancellations can result in the inability to accommodate your schedule.

Insurance Plans:

- You are responsible for your co-payment and your yearly deductible at each visit.
- We accept assignment of insurance payments, but you are ultimately responsible for any charges the insurance company does not pay.

Finance Charges:

- All accounts unpaid for over 60 days are subject to an additional administrative fee and/or possible collections activity.

No insurance visits:

- We accept patients who do not have dental insurance or patients who would rather pay for the dental services out of pocket.
- Initial visit $220-includes: comprehensive exam, 4 bitewing x-rays and a regular cleaning. Any additional treatment that may be needed will have a separate cost.
- We do not bill for the dental services rendered. All payments will be collected at the time of each visit.

Patient Signature

Date