Welcome! *We are pleased that you have chosen to allow us to meet your dental and wellness needs. Our practice is distinguished by our commitment to exceptional personalized service, outstanding comprehensive care and our genuine concern. Please feel free to ask any questions during your intake.*

Bradburn Village **Dentistry**

Confidential Information:

Name: Last_____ First _____ Middle Initial _____

(Preferred Name)_____ How did you hear about us? _____

Address_____

City _____ State _____ Zip _____

Phone: Cell _____ Work _____ Home _____

Primary E-mail_____ Preferred Method of Contact_____

Birth Date_____ SSN _____ Marital Status_____

Occupation_____ Current Employer_____

Employer Address_____

City _____ State _____ Zip _____

Emergency Contact Name & Phone: _____ Relationship: _____

Hobbies & Passions: _____

Insurance Information:

Name of Primary Insured: ☐ Same as above *(Please give our front office staff your dental/medical insurance card)*

Last Name _____ First Name_____ Middle Initial _____

Birth Date_____ SSN_____

Insured's Employer_____

Member ID Number _____ Group Number_____

Insurance Name_____ Phone Number_____

Address_____

City _____ State _____ Zip _____

Additional Insurance_____

*Our medical history paperwork is holistic in nature. Our goal is to understand the full picture of your dental/health concerns and what may be at the root of them. Thank you for answering thoroughly and honestly. Please mark the box **Yes** for any condition that you have **previously experienced** or **currently have** and **No** if you have never had it.*

Your physician is_____ Physician Phone #_____

*(**Check all that apply**)*

Have you ever had an adverse reaction to:

□ Local Anesthetics/Novocain • Codeine □ Antibiotic _____

□ Other_____ □ Aspirin/Advil □ Latex

Do you take:

□ Blood thinners (e.g Coumadin, Plavix, etc.) *if yes*, date and score of most recent INR _____

□ Any other medications, vitamins or supplements, if so, please list:

Name of medication	What condition you take it for
_____	_____
_____	_____
_____	_____

(List any additional meds you take on separate sheet)

Other Medical conditions *(Check all that apply)*

□ Asthma *if yes*, where do you keep your inhaler?_____

□ Bleeding problems	□ Epilepsy	□ Prosthetic heart valve	□ Artificial joint
□ Hepatitis	□ Tuberculosis	□ HIV/AIDS	□ Thyroid Disease
□ Cancer	□ Chemo/radiation	□ Sleep apnea	□ Steroid Use
□ Kidney Problems	□ Psychiatric therapy	□ Change in health in last year	□ Any Addiction
□ Breathing/COPD	□ Heart Disease	□ Vertigo	□ Cold Sores/fever blisters

Gum disease has been linked with an increased risk for many chronic diseases. Eliminating gum disease is especially important to the oral *and* overall health of the following patients: *(Please check all that apply)*

□ Tobacco user

Tobacco users are more likely to develop gum disease which is more severe and more difficult to eradicate. Gum disease itself has recently been linked with an increased risk for heart disease. Since tobacco users are already at an increased risk for heart disease (and since gum disease only worsens that risk) it is vitally important for tobacco users to do whatever is necessary to eliminate gum disease.

Current Tobacco user → What form (cig, pipe, chew, vaping, etc). _____

How much/day_____ For how long_____

Previous Tobacco user → When did you quit_____

□ Diabetes

Diabetes is a well- known risk factor for gum disease. Research is confirming that when left untreated gum disease makes it harder for you to control your blood sugar. Elimination of gum disease can improve your blood sugar control reducing your risk for the serious complications.

How is your diabetes control? Good Fair Poor

Date of last A1c_____ What score?_____

Who is your diabetes Doctor_____ Phone #_____

□Blood Press	*BP* _____ ◊ *Advised to see med referral* ◊ *Treatment Contraindication* Pre-Hypertension 120-139 Systolic OR 80-89 Diastolic Stage1 140-159 Sys OR 90-99 Dia Stage 2 >160 Systolic OR >100 Diastolic CONTRAINDICATED 160/100
□ Stress	Stress is a well- known risk factor for gum disease. Is your stress level too high? Yes No Life altering events (loss of job, divorce, death in family, moving to new location, etc.) can be particularly strong factors for gum disease. Are you currently going through and life altering events? Yes No
□ Rheumatoid Arthritis	There is a bi-directional connection between rheumatoid arthritis. If you have arthritis you are at an increased risk for gum disease. Emerging research suggests that eliminating any gum disease and then keeping it at bay can lessen the crippling effects of arthritis. Have you ever been diagnosed with Rheumatoid Arthritis? Yes No

All patients please complete the following (check all that apply)

□ Heart disease/risk factors for heart disease (family history of heart disease,□ cholesterol, □ blood pressure

□ Spouse with gum disease (Gum disease may be transmissible, family members should be screened for gum disease)

□ Taking Dilantin, Ca+ Channel Blockers, or Immunosuppressants for organ transplantation

□ Previous bouts of gum disease

□ History of gastric ulcers

□Kidney Disease

□ Family history of Alzheimer's disease

□ Respiratory disease

□ Family history of colon cancer

FEMALES Are you: Pregnant Nursing Taking birth control pills

Ever diagnosed with breast cancer? Family history of breast cancer? Post-menopausal?

Do you have osteoporosis?

Yes No → Have you ever been tested for osteoporosis? Yes No

Ever taken *Fosamax, Fosamax Plus D, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefors*, or *Zometa* for osteoporosis or for any other reason? Yes No

Sleep apnea is an under diagnosed condition with serious, life threatening consequences. Some of the earliest signs/symptoms of a Sleep Related Breathing Disorder (SRBD) may be observed in the mouth. Therefore, Dental Professionals are on the front lines of screening for SRBD's.

Feeling sleepy often during the day:
Yes
No

Severe overweight or large neck size:
(neck circumference over 17 inches in males, over 16 inches in females)
Yes
No

Forgetfulness, confusion or frequent accidents:
Yes
No

Occasional breathing pauses at night:
Yes
No

Awakening frequently at night with heartburn, night sweats or feel wide awake in middle of night:
Yes
No

Morning headaches, even occasionally:
Yes
No

Irritability or mood change:
Yes
No

Require naps or nodding off occasionally from being sleepy:
Yes
No

Overweight, especially if difficult to control:
Yes
No

Loud snoring, or snore more than 3 times a week:
Yes
No

Irregular night breathing, followed by a gasp or snort
or mouth breathing:
Yes
No

Awakening in the morning still feeling tired, groggy:
Yes
No

Suffer from Gastric Reflux:
Yes
No

◊ Advised referral to MD
◊ Being Managed by MD_____
◊ CPAP
◊Appliance

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist_____ How long have you been a patient? _____Months/Yrs

Date of most recent dental exam_____ Date of most recent dental x-rays _____

Date of most recent dental treatment (other than a cleaning)_____

I routinely see my dentist every: ☐ 3 mo ☐ 4 mo ☐ 6 mo ☐ 12 mo ☐ Not routinely

What is your immediate concern _____

Please answer YES or NO to the following:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very)_____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____	☐	☐
5. Did you have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth you would like to change? _____	☐	☐
8. Have you ever whitened (bleached) your teeth? _____	☐	☐
9. Are you self-conscious about your teeth ?_____ _____	☐	☐
10. Have you ever been disappointed with the appearance of previous dental work? _____	☐	☐
BITE & JAW JOINT		
11. Do you / would you have any problems chewing gum? _____	☐	☐
12. Do you / would you have any problems chewing bagels or other hard foods? _____	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
14. Are your teeth crowding or developing spaces? _____	☐	☐
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? ____	☐	☐
16. Do you have any problems with your sleep or wake up with an awareness of your teeth? _____	☐	☐
17. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? ____	☐	☐
18. Do you have tension headaches or sore teeth?_____	☐	☐
19. Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years? _____	☐	☐
21. Do you have a dry mouth? _____	☐	☐
22. Are any teeth sensitive to hold, cold, biting or sweets? _____	☐	☐
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	☐	☐
24. Do you avoid brushing any part of your mouth?_____	☐	☐
25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____	☐	☐
GUM & BONE		
26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
27. Have you ever experienced gum recession? _____	☐	☐
28. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
29. Do your gums bleed when brushing, flossing or eating? _____	☐	☐
30. Are you teeth becoming loose? _____	☐	☐
31. Have you noticed an unpleasant taste or odor in your mouth? _____	☐	☐
32. Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient Signature: _____ Date_____

Doctor's Signature: _____ Date_____

Bradburn Village Dentistry
Financial Policy

Bradburn Village Dentistry would like to welcome you to our practice! We believe in creating vibrant and healthy smiles beginning with the overall health of your mouth. Everyone benefits when office and financial policy arrangements are understood so that we may have a definite understanding in regards to the payment for dental services. The following is our policy:

Your insurance coverage is based upon a contract made between your employer and an insurance company. If you have any questions regarding coverage please contact your employer or dental insurance company directly. Dental benefit plans are only made to **assist** you with your dental needs, not pay for it completely.
(Initial) _____

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list) and we are in-contract with a select few insurance companies that require us to drop to an agreed-upon fee. This means we work with hundreds of insurance companies and although we keep a history of payments, they change. This makes it **impossible** to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information **but it is only an estimate.**
(Initial) _____

We bill your insurance company as a courtesy. If insurance does not pay within 60 days, Bradburn Village Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance that you have is a **LEGAL contract between you and your insurance company.** The office is not, and **cannot,** be part of that legal contract. **Ultimately, you are responsible for all charges incurred in our office.**
(Initial) _____

Bradburn Village Dentistry **does require payment in full for your portion at the time of scheduling service.** We accept all major credit cards, cash and checks (checks are accepted only from existing patients with an established payment history). We also work with Care Credit and other financing programs. There will be a 1.5% per month (18% per year) service charge on balances over 60 days. Should this account be turned over to a collection agency, I agree to pay all costs of collection, including but not limited to, court cost and attorney fees.
(Initial) _____

Missed/Canceled Appointments: A specific amount of time has been reserved especially for you when you schedule an appointment. We require **a 48 hour notice** if you must change or cancel your appointment. If there is not a 48 hour notice, you will be subject to a rescheduling fee of $100.00 per scheduled hour.
(Initial) _____

Patients are required to keep a credit card on file with Bradburn Village Dentistry and may be required to sign an automatic debit form for a credit card number if a payment plan has been agreed upon for treatment. We will work with you in establishing a payment schedule if necessary using this credit card authorization.
(Initial) _____

I understand that my credit card will be charged if my insurance says I am responsible for a deductible, co-insurance or any remaining balance after insurance reimbursement.
(Initial) _____

Name:_____ Signature:_____ Date: _____

Credit Card on File Agreement

Bradburn Village Dentistry has implemented a new credit card policy. Much like many other businesses such as a hotel or car rental agency, attorneys, etc. we now have a similar policy where we ask for a credit card which may be used later to pay any balance that may be due on your bill.

Patient's full amount is still due at the time of scheduling.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will receive a text and an email 7 days before your card is charged letting you know the amount.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize Bradburn Village Dentistry to keep my signature and my credit card information securely on file in my account. I authorize Bradburn Village Dentistry to charge my credit card for any outstanding balances. These may include: insurance denials; partially paid claims, missed or canceled appointment; deductibles. Missed or canceled appointments without 48-hour notice will be charged a rescheduling fee.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Bradburn Village Dentistry a new, valid credit card which I will allow them to charge over the telephone. If not we reserve the right to charge an additional $25 declined card fee if not able to run a new card within 7 days. Even though Bradburn Village Dentistry is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented

☐Visa ☐MasterCard ☐Discover ☐American Express

Patient's Name (Print): _____ DOB: ___/___/_____

Name on Card (Print): _____

Credit Card Number: _____Exp. Date: ____/_____CV:_____

Please fill out information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: ___/___/_____

Patient Full Name (Print): _____ DOB: ___/___/_____

Patient Full Name (Print): _____ DOB: ___/___/_____

Credit Card Holder's Signature: _____Date: _____

Frequently Asked Questions Regarding the Credit Card on File Agreement

Why the change?
There are several reasons. First, statements are wasteful of paper, stamps and envelopes. Second, we need to ensure that we have a guarantee of payment on file in our office.

But I always pay my bills, why me?
We have to be fair and apply the policy to all patients. We have wonderful patients, and we know that most of you pay your balances. Unfortunately, this is not the case every time. Nothing is changing about how much you end up paying.

How will I know how much you are going to charge me?
You will receive a letter in the mail from your insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB). This letter tells you exactly, according to your dental insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. If you disagree with the patient's responsibility, it is your responsibility to contact your insurance carrier immediately.

Then What?
When we receive the EOB, we will enter all pertinent payment information into our system. You will receive an email and a text 7 days before your card is charged letting you know the amount. We will email you a copy of your receipt.

But wait, I'm nervous about leaving you my credit card.
We do not store your sensitive credit card information in our office. We store it on a secure website called a gateway. We access your information on this site only to process a payment.
We follow the Payment Card Industry Data Security Standards to the letter and will not compromise your data security. Health Care practices are used to having to secure information under HIPAA laws, and we already have policies in place for any credit card information we come into contact with.
Keeping the patient's card on file, offsite, in an encrypted payment gateway enhances security because there are fewer human touches in the process that can invite fraud. If patients swipe their cards at every checkout for time of service payments, then their card date is exposed at every visit. If the card is handed to an employee to swipe, the card is exposed magnetically and it is exposed to another human being. With a credit card on file system, after the initial swipe, the patient doesn't even have to bring the credit card to the visit, or enter the PIN during the visit.

What if I need to dispute my bill?
We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier in the same way that we normally determine how much to send you a bill for in the mail.

What if I don't have insurance?
Self-pay patients are expected to pay for services in full at the time of scheduling. This includes patients that we do not participate in their insurance plan and patients who are on the Bradburn Dental Plan.

What if I don't have a credit card?
We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account) or Flex Plan Card on file. You may also pay for the visit with cash or a personal check. If you do require a paper statement for this there will be a $5 billing fee attached.

Authorization for Use or Disclosure of Patient Photographic and/or Video Images

At Bradburn Village Dentistry, there are a variety of reasons why we believe photos to be of such high importance. Photographs are an excellent resource for our providers to use and establish a baseline of your mouth, so we can monitor if there are any changes we need to be concerned about. They also help our providers create a personalized pathway to health for you.

Most importantly, at Bradburn Village Dentistry, we believe in the importance of photographs for YOU! The use of high quality images allows our providers to show you what they see and any areas of concern. Photographs also show you the results of your treatment, and allow you to compare your results to your previous photographs.

Not only can your photographs keep you informed and aware of your personalized pathway to health, your smile transformation and story might just be what another patient needs to start their own journey.

Bradburn Village **Dentistry**

Authorization: I authorize the use and disclosure of my photographic/video images, and/or testimonial, including any medical information contained therein, to Bradburn Village Dentistry, its business associates, employees, licensees, and successors. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy/regulations and the HITECH Act. I do NOT authorize the use of my name.

Purpose: The photographic/video images, and/or testimonial will be used for promotional materials including brochures, press releases, websites, social media and education materials and advertising activities of Bradburn Village Dentistry.

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received via registered mail. Revocation affects disclosure moving forward and is not retroactive.

No Treatment Conditions: I understand that my practitioner cannot condition treatment on whether or not I sign this authorization.

Expiration: This authorization with expire [____] years after the date indicated below

- "Yes, I would like a copy of this form."
- "No, I would not like a copy of this form."

Patient Name: _____Signature: _____Date: _____

If Personal Representative:

Patient Name: _____Signature: _____Date: _____

Relationship to Patient: _____

If Patient is a Minor:

Patient Name: _____Parent/Legal Guardian Name: _____

Signature: _____ Date :_____

Bradburn Village Dentistry Notice of Privacy Practices

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.

Bradburn Village Dentistry, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 03/25/2015. You may access or obtain a copy according to the following options: 1) our website at www.cosmeticdentistrydenver.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you. A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist. B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided. C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff. i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows: D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection: E) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider. F) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a postcard or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated. G) Family, Close Friends, Personal Representatives & Caregivers: Our staff may disclose to a person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best Interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in

compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement. H) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you: **A)** Copy of this Notice: You have the right to a copy of this notice including a paper copy. **B)** Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details). **C)** Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice. **D)** Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.
E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request. **F)** Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosure exceptions to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer. **G)** Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. “Unsecured” is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you. **H)** Fundraising: If PHI is used for fundraising which is considered “health care operations,” basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals’ have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at: Bradburn Village Dentistry 303-466-3222.
You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Bradburn Village Dentistry. I hereby authorize, as indicated by my signature below, Bradburn Village Dentistry to use and to disclose health information for any necessary clinical, financial, and insurance purpose as authorized in the Patient Consent Form.

_____ _____

Print Name Full Address

_____ _____

Signature Date

Please check your preferred means of communication:

- You may contact me at my home telephone number:_____
- You may contact me at my mobile telephone number:_____
- You may contact me at my work telephone number:_____
- You may send me an unencrypted email/text message at: _____
- Other: _____

Please list authorized person with whom we may discuss your Protected Helth Information (PHI) in the addition to custodial and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____
4. _____ Date Added / Removed: _____

*****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
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other (please specify) _____