HIPAA - NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact:

Bryn Mawr Dental Associates
945 Haveford Road
Bryn Mawr, PA 19010
Phone: 610-527-2469

WHO WILL FOLLOW THIS NOTICE
This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION
This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.
We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
For Treatment
We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.
Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.
For Payment
We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.
For Health Care Operations
We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.
Appointment Reminders
We may contact you as a reminder that you have an appointment for treatment or medical care at the office.
Treatment Alternatives
We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
Health-Related Products and Services
We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS
We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:
To Avert a Serious Threat to Health or Safety
We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Required By Law
We will disclose health information about you when required to do so by federal, state or local law.
Research
We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
Organ and Tissue Donation
If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
Military, Veterans, National Security and Intelligence
If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
Workers' Compensation
We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks
We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
Health Oversight Activities
We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
Law Enforcement
We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
Coroners, Medical Examiners and Funeral Directors
We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
Information Not Personally Identifiable
We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
Family and Friends
We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION
We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:
Right to Inspect and Copy
You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to us in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
Right to Amend
If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.
Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.
To obtain this list, you must submit your request in writing to us. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions
You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.
We are Not Required to Agree to Your Request
If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to us.
Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:
We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

CHANGES TO THIS NOTICE
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

You will not be penalized for filing a complaint.

Date: _____ **Name:** _____ **DOB:** _____

Personal Information

Questions	***Answers***
PATIENT INFORMATION.	
Marital Status:	Single
	Married
	Separated
	Divorced
	Widowed
	Minor
Social Security:	
E-mail:	
Home Phone:	
Work Phone:	
Cell Phone:	
Driver's License#:	
Home Address:	
City/State/Zip:	
Billing Address:	
City/State/Zip:	
Patient's Employer:	
Occupation:	
Preferred Method of Contact:	Phone
	Email
	Either Phone or Email
Person to contact in case of an emergency?	
Phone:	
Relationship to Patient:	
Whom may we thank for referring you?	
FINANCIAL INFORMATION.	
Name of a Guarantor - person responsible for paying the bill:	
Social Security:	
Relationship to Patient:	Self
	Parent
	Grandparent
	Guardian
	Family member
	Relative
	Other
If you have any insurance, please complete the following. If not, click Next button below.	
PRIMARY INSURANCE INFORMATION. Name of Insured:	
Date of Birth:	
Social Security:	
Employer:	
Policy/ID#:	

Date: _____ **Name:** _____ **DOB:** _____

Personal Information

Questions	***Answers***
Group #:	
Coverage Type:	Individual
	Family
	Prepaid / Capitation
Insurance Company:	
Company Phone Number:	
Company City/State/Zip:	
If you have any additional insurance, please complete the following. If not, click Next button below.	
SECONDARY INSURANCE INFORMATION. Name of Insured:	
Date of Birth:	
Social Security:	
Employer:	
Policy/ID#:	
Group #:	
Coverage Type:	Individual
	Family
	Prepaid / Capitation
Insurance Company:	
Work Phone:	
City/State/Zip:	

I authorize Bryn Mawr Dental Associates (BMDA) to release any information, including diagnosis, treatment plans/records and radiographs to third party payors and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dental benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment. I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies (including any interest, late fees, and all costs of collection, including, but not limited to, attorney's fees and court costs) incidental to payment for such services.

Signature: _____

Bryn Mawr Dental Associates
945 Haveford Road Bryn Mawr, PA 19010
Phone: 610-527-2469

Date: _____ **Name:** _____ **DOB:** _____

Medical History Questionnaire

Questions	***Answers***
Please complete the following questions. If you need to add comments, please write them in the box next to each answer.	
Physician's full name?	
City, State and Zip:	
Are you currently under a physician's care? If Yes, please use Comments to describe.	Yes
	No
Have you been hospitalized in the last two years? If Yes, please use Comments to describe.	Yes
	No
Are you taking any medication(s), drugs or pills? If so, please use Comments to list names and dosages of each.	Yes
	No
Do you smoke or use tobacco products? If Yes, please use Comments to describe how much.	Yes
	No
Are you allergic to or have you had any reactions to the following?	Local anesthetics (e.g. Novocain)
	Sedatives, dental anesthetics
	Penicillin or any other antibiotics
	Aspirin
	Erythromycin
	Tetracycline
	Codeine
	Sulfa drugs
	Barbiturates
	Iodine
	Any metals (e.g. nickel, mercury, etc.)
	Latex rubber
	Other
Do you have or have you had any of the following?	Pre-Medication required
	Heart attack
	Heart murmur
	Chest pains
	Congenital Heart Problem
	Artificial Heart Valve
	Mitral Valve Prolapse
	Heart surgery
	Pacemaker
	High/Low Blood Pressure
	Rheumatic fever
	Anemia
	Stroke
	Hemophilia, abnormal bleeding

Date: _____ **Name:** _____ **DOB:** _____

Medical History Questionnaire

Questions	***Answers***
Do you have or have you had any of the following?	Glaucoma
	Diabetes
	Scarlet Fever
	Hepatitis A or B
	Cancer
	X-Ray or Cobalt treatment
	Ulcers
	Lung Disease
	Tuberculosis (TB)
	Asthma
	Arthritis / Gout
	Artificial Joint replacement
	Psychiatric Care
	Epilepsy or Seizures
	Fainting or Dizziness
	Cold sores / Fever blisters
	AIDS or HIV positive
	Sexually transmitted diseases (STD)
	Herpes
	Chemical Dependency
	Other
Women only: Are you pregnant or think you may be pregnant? If Yes, please use Comments to specify how many weeks.	Yes
	No
Women only: Are you nursing?	Yes
	No
Women only: Are you taking oral contraceptives (birth control pills)?	Yes
	No
Women only: Are you on Hormone therapy?	Yes
	No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____

Bryn Mawr Dental Associates
945 Haveford Road Bryn Mawr, PA 19010
Phone: 610-527-2469

Date: _____ **Name:** _____ **DOB:** _____

Dental History Questionnaire

Questions	***Answers***
Please complete the following questions. If you need to add comments, please write them in the box next to each answer.	
What is your primary reason for seeking dental care?	
PREVIOUS DENTIST INFORMATION: Full name:	
City, State and Zip:	
Date of last dental visit?	
What was done at your last visit?	
Date of last full mouth X-Rays?	
Reason for leaving previous dentist:	
How often do you have dental examinations?	Annual checkup
	Twice a year checkup
	Only when I have a problem
	Other
PLEASE CHOOSE THE APPROPRIATE ANSWERS BELOW: Are you nervous about receiving dental treatment?	Yes
	No
Do you gag easily?	Yes
	No
Have you had previous problems with dental care? If so, please use Comments to explain.	Yes
	No
Are your teeth sensitive to hot, cold, pressure or sweets?	Yes
	No
Do you have problems with teeth/fillings breaking?	Yes
	No
Are you aware of an uncomfortable bite?	Yes
	No
Do your gums feel tender and/or bleed?	Yes
	No
Does food catch between your teeth?	Yes
	No
Have you had periodontal (gum) treatments?	Yes
	No
Do you get sores in or around your mouth?	Yes
	No
Do you have regular headaches, earaches or neck pains?	Yes
	No
Do you grind or clench your teeth?	Yes
	No
Do you hear a "clicking" sound when you open/close your mouth?	Yes
	No
Does your jaw ever get "stuck?"	Yes
	No

Date: _____ **Name:** _____ **DOB:** _____

Dental History Questionnaire

Questions	***Answers***
Do you have a Temporomandibular (TMJ) jaw disorder?	Yes
	No
Are you missing teeth that have not been replaced?	Yes
	No
Have you had excessive bleeding after an extraction?	Yes
	No
Have you had mouth sores that take long to heal?	Yes
	No
Do you have any dental implants?	Yes
	No
Do you wear dentures (partials or full)?	Yes
	No
Do you have any crowns (caps) or bridges?	Yes
	No
Do you have a dry mouth?	Yes
	No
Are you unhappy with the appearance of your teeth?	Yes
	No
Would you like your smile to look better?	Yes
	No
Would you like whiter teeth?	Yes
	No
Do you regularly use dental floss?	Yes
	No
Do you brush at least once daily?	Yes
	No
Is there anything else that you would like us to know? Please use Comments for more space.	
I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site.	Yes
	No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____

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