Welcome and thank you for choosing **Guilderland Family Dentistry**! We would like to take this opportunity to introduce you to our practice and to offer assistance in making your visit a comfortable one. The initial visit for adult will take approximately 60 minutes. Children and teens should plan on approximately 40 minutes. Please bring a photo ID and any insurance cards with you. The Federal Trade Commission now mandates that all adult patients present a valid photo ID in hopes of preventing identity theft.

New Patient Forms:
We will need a Health history form, a Patient information form and a HIPAA form from you. These forms are available online www.GuilderlandFamilyDentistry.com under new patient. Please fill out the New Patient Registration and Medical History Forms before your initial appointment.

Financial Policy:
Guilderland Family Dentistry will gladly file dental insurance claims for all of your visits to our office. It is not the responsibility of Guilderland Family Dentistry to know your insurance carrier benefits. It there is a deductible or co-payment due from you, it is expected at the time of service. After 90 days, any portions not paid by your insurance provider become your responsibility.
Minor Children of divorced parents are the legal responsibility of both parents. Because Guilderland Family Dentistry will not become engaged in a dispute for payment of services, the parent who consents to treatment will be legally responsible for payment of any series provided to a minor child.

Appointments and Cancellation Policy:
Guilderland Family Dentistry makes every attempt to schedule your appointments at times that are most convenient for you. We are open at 8:00am from Monday through Thursday and phone is available from 7:30am. There may be times when our practice experiences delays because of emergencies or the discovery of a more serious problem that requires immediate attention. Rest assured that we are making every effort to honor your time and give you the attention you need. Guilderland Family Dentistry asks that if you cannot keep you appointment time that you give us 24 hours notice of cancellation. In the event of a no show or same day cancellation, a $50.00 broken appointment fee may be assessed.

Treatment Estimates:
Before any treatment is initiated, we consult with our patients to ensure there is full understanding of the need for treatment, the procedure by which treatment will be rendered, and the estimated cost of the treatment. Just as with any health condition, the discovery of a more substantial problem during a procedure can alter the recommended course of action. We will always keep you apprised of any changes necessary, your options in procedures, and how they affect the cost of treatment.
Thank you for choosing Guilderland Family Dentistry to take care of all your dental health care needs. We strive to be perceptive and sensitive to the feelings of our patients at all times; to be empathetic and sympathetic to their physical and emotional needs. Above all, we strive to give each patient the best quality of dental care in every possible respect, constantly updating our knowledge and methodology.

We look forward to being your dentist and your friend.

The Team of Guilderland Family Dentistry

Guilderland Family Dentistry
3734 Carman Road
Schenectady, NY 12303
(T) 518-356-0077 (F) 518-356-0067

REQUEST FOR RELEASE OF INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS:_____

TYPE OF RECORD: _____DENTAL RECORDS _____X-RAYS _____OTHER _____

I HEARBY REQUEST AND AUTHORIZE (YOUR PREVIOUS DENTIST): _____

TO RELEASE ANY DENTAL RCORDS ON THE PATIENT LISTED ABOVE:

EUNHAE PARK, DDS
3734 CARMAN RD
SCHENECTADY, NY 12303
(518) 356-0077
GuilderlandFamilyDentistry@gmail.com

SIGNATURE OF PATIENT:_____ DATE: _____

NOTICE OF PRIVACY PRACTICES –HIPAA

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.

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, weather 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, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operation include the business aspects of running our practice, such as conducting quality assessment of 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 alternative 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 request 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 request 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 to you a paper copy of this notice from us at your first service 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 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 information.

This notice is effective March 20, 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 formal, written complaint with us at the address below, or with the Department of Health & Human Services Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate again you for filling a complaint. Please contact us for more information:

Guilderland Family Dentistry 3734 Carman Rd Schenectady ,NY 12303

For more information about HIPAA or to file a complaint:

Centralized Case Management Operation: U.S. Department of Health and Human Services 200 Independence Ave Room 509 F HHH Bldg Washington, DC 20201 Toll Free (877)-696-6775

HIPAA Acknowledgement Consent Form

By signing this I am acknowledging that I have read and understand this Office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of Privacy Practices. I understand that, by signing this acknowledgement and consent form that I am giving my consent for this office's use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Patient Name (Please Print): _____

Signature: _____

Date: _____

If this acknowledgement is signed by a personal representative on behalf of the patient please complete the following

Guardian or Personal Representative's Name: _____

Signature: _____

Date: _____

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Due to out of network status, my insurance company may issue the check and/or the Explanation of Benefits (EOB) directly to me. I understand that it is my responsibility to promptly forward them to Guilderland Family Dentistry.

PRINT NAME:_____ DATE: _____

SIGNATURE: _____ DATE: _____