Bielozer FAMILY DENTAL

Date_____

Whom may we thank for referring you?_____

PATIENT INFORMATION

Patient Name _____Preferred Name_____
Address _____City/State_____ Zip Code_____
Home Phone _____Work Phone_____ Cell Phone_____
Email Address _____Best time of day and which phone # to reach you_____
Important Note: **(We use the cell phone number and email address to remind patients of future appointments)**
Sex Female/Male Age_____ Birthdate _____Marital Status_____ SSN_____
Employer_____ Occupation_____
Employer Address _____Employer Phone_____
Spouse Name_____ Birthdate_____ SSN_____

GUARDIAN INFORMATION (if applicable)

Patient Name _____Preferred Name_____
Address _____City/State_____ Zip Code_____
Home Phone _____Work Phone_____ Cell Phone_____
Email Address _____Best time of day and which phone # to reach you_____
Birthdate_____ SSN _____
Employer_____ Occupation_____
Employer Address _____Employer Phone_____
Who is responsible for this account?_____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company_____
Name of Primary Policy Holder_____ Birthdate_____
SSN_____ Relationship to the patient_____
Policy # _____ Group #_____
Union or Local # _____ Anniversary Date of Policy_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Relationship Date

EMERGENCY INFORMATION

Whom may we contact in case of an emergency? _____Relationship_____
Home Phone _____Work Phone_____ Cell Phone_____

29732 Lorain Rd., North Olmsted, OH 44070
Tel: (440)771-2777 Fax: (440)771-2778

Bielozer FAMILY DENTAL

Patient Name_____
Birthdate_____

DENTAL HISTORY

Reason for today's visit_____
Former Dentist _____Phone #_____ City/State_____
Date of Last Dental Visit _____Date of last dental X-Rays_____
Date of Last Dental Cleaning_____
How often do you brush your teeth?_____ How often do you floss?_____
What other dental aids do you use? Manual Toothbrush_____ Soft_____ Medium _____Hard_____
_____Toothpick _____Fluoride Rinse _____Electric Toothbrush Other_____
Have you received any formal oral hygiene instruction? Y / N How long ago?_____
Do you like your smile? Y / N
How do you feel about the appearance of your teeth?_____
What do you wish could be changed?_____
Are you interested in straightening your teeth (Orthodontic treatment)? Y / N Have you had braces before? Y / N

Please circle YES or NO to indicate if you have had or currently have any of the following:

Cold Sores or growths in mouth	Y N	Grinding teeth	Y N	Lip or cheek biting	Y N
Sensitivity when biting	Y N	Swollen Gums	Y N	Difficulty with any dental work	Y N
Pain around ear	Y N	Hold foreign objects w/your teeth	Y N	Loose teeth	Y N
Sore or Bleeding gums	Y N	Clenching teeth	Y N	Clicking or Popping of the jaw	Y N
Sensitivity with sweets	Y N	Dry Mouth	Y N	Problems getting numb	Y N
Change/Shift in your bite	Y N	Chew on one side of mouth	Y N	Broken fillings	Y N
Blisters on lips or mouth	Y N	Chewing tobacco	Y N	Difficulty opening or closing mouth	Y N
Sensitivity to cold	Y N	Bad Breath	Y N	Wear a bite plate or mouth guard	Y N
Experience pain in jaw joint	Y N	Fingernail biting	Y N	Frequent headaches	Y N
Burning sensation on tongue	Y N	Smoke (circle) Cigarette, pipe, cigar	Y N	Tired jaws, especially in the morning	Y N
Sensitivity to heat	Y N	Mouth breathing	Y N	Excessive stress or pressure	Y N

A serious injury to the mouth or head Y N Please describe including the cause _____
Food collection between teeth Y N Please indicate location_____
Oral Surgery (Extractions) Y N
Endodontic Treatment (Root Canals) Y N
Periodontal Treatment (Gums- Deep Cleaning) Y N If yes: please indicate

- Osseous Surgery Date_____
- Tissue Gingival Grafts Date_____
- Tissue Management (Scaling, Curetage) Date _____

Do you feel nervous about having dental treatment? Y N
Have you ever had an upsetting dental experience? Y N
Is there anything else about having dental treatment that you would like us to know? Y N
If yes to any of the above, please describe _____

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Bielozer FAMILY DENTAL

Patient Name_____

Birthdate_____

MEDICAL HISTORY

Physician's Name _____Date of Last Visit_____
Address _____City_____ State_____ Zip Code_____
Have you been under the care of a medical doctor during the past two years? Y N
If yes, for what?_____
Please check yes or no to indicate if you have had any of the following:

AIDS / HIV positive	Y N	Emphysema	Y N	Pacemaker	Y N
Alcoholism/Drug Abuse	Y N	Epilepsy or Seizures	Y N	Psychological Problems	Y N
Anemia	Y N	Fainting or Dizzy Spells	Y N	Psychiatric Care	Y N
Arthritis, Rheumatism	Y N	Glaucoma	Y N	Radiation Treatment	Y N
Artificial Heart Valves	Y N	Hay Fever	Y N	Respiratory Disease	Y N
Asthma	Y N	Headaches	Y N	Rheumatic Fever	Y N
Back Problems	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
Bleeding Abnormally	Y N	Heart Problems	Y N	Shortness of Breath	Y N
Blood Disease	Y N	Hemophilia	Y N	Sickle Cell Disease	Y N
Blood Transfusion	Y N	Hepatitis Type _____	Y N	Sinus Trouble	Y N
Cancer	Y N	Herpes	Y N	Skin Rash	Y N
Chemical Dependency	Y N	High Blood Pressure	Y N	Stomach Disorder (Ulcers)	Y N
Chemotherapy	Y N	High Cholesterol	Y N	Stroke	Y N
Circulatory Problems	Y N	Jaundice	Y N	Swelling of Feet or Ankles	Y N
Congenital Heart	Y N	Jaw Pain	Y N	Swollen Neck Glands	Y N
Contact Lenses	Y N	Joint Replacement When / Type__	Y N	Thyroid Problems	Y N
Cortisone Treatments	Y N	Kidney Disease	Y N	Tonsillitis	Y N
Cough, Persistent/Bloody	Y N	Liver Disease	Y N	Tuberculosis	Y N
Cysts/Tumors Where_____	Y N	Low Blood Pressure	Y N	Tumor/Growth on Head or Neck	Y N
Diabetes	Y N	Mitral Valve Prolapse	Y N	Ulcer	Y N
Diet (Restricted / Special)	Y N	Neurological Disorders	Y N	Venereal Disease	Y N
Eating Disorders	Y N	Nervous or Anxiety Problems	Y N	Weight Loss or Gain, Unexplained	Y N

Allergies [ ] NONE [ ] Amoxicillin [ ] Aspirin [ ] Barbiturates [ ] Codeine [ ] Epinephrine
[ ] Erythromycin [ ] Keflex [ ] Iodine [ ] Latex [ ] Lortab [ ] Morphine
[ ] Penicillin [ ] Sulfa [ ] Tetracycline [ ] Other _____

List medications currently taking (name and dosage) _____

_____

Do you have or have you had any disease, condition or problem not listed above? Y N
If yes, please explain:_____
Do you need to take any antibiotics (pre-medicate) before any dental appointment? Y N
Have you been in the hospital or had a serious illness within the past five years? Y N
If yes, Please explain: _____
Women: Are you pregnant? Y N Due date_____ Are you nursing? Y N Do you take Birth Control Pills? Y N
Are you taking any Blood thinners? Y N If Yes, Please List _____

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Parent / Guardian Signature X _____Date _____
Doctor Signature _____Date _____

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Bielozer FAMILY DENTAL

Patient Name_____

Birthdate_____

Broken or cancelled appointments

Your appointment time is valuable and has been reserved specifically for you. If you need to cancel an appointment, please notify us **at least 24 hours in advance** for Tuesday through Friday appointments and no later than 2:00 pm Friday for Monday appointments. We charge **$100.00** for each canceled or broken appointment if you do not give us the required advance notice. Please notify us if an emergency makes it impossible for you to give 24 hours notice so we can discuss this with you.

If you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the dentist's schedule can still accommodate you.

Signature of patient or responsible person I acknowledge and understand the cancellation policy

X_____ *Date*____

Insurance and Financial Agreement

Our practice is in-network for most dental insurance carriers, and we are a PPO provider. Please provide your insurance card on your first visit, and let us know of changes in coverage or carriers on subsequent visits. As a courtesy, our office files all necessary paperwork with your insurance company; our friendly staff will be happy to help you maximize your dental benefits. Many dental insurance policies have exclusions and limitations that can affect your out-of-pocket cost.

At the time of service you will need to pay the expected estimated insurance deductible and any estimated amount that we expect your insurance will not cover. Remember that many procedures may not be fully covered; in those instances, you are responsible for the remaining amount. However, please remember that your dental insurance policy is a contract between you, your employer and the insurance company. Please keep in mind that you are responsible for the total amount should your insurance benefits result in less coverage than anticipated.

Before proceeding with treatment, we will provide a written estimate of fees, however we try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits. Also, some companies take care of claims promptly while others delay payment for several months. After 60 days from the treatment day if payment is not received from your insurance, the payment will be due in full from you and the insurance company will be reimbursing you. Please understand that we cannot accept responsibility for collecting your insurance claim or for negotiating disputed claims between you and your insurance company.

We want you to feel comfortable and confident in all aspects of our practice. Remember we do not treat according to your insurance we treat you as an individual and care about your dental health, and are dedicated to providing the best treatment available to our patients.

I have read, understand and agree to the above financial agreement. Any questions and concerns were answered fully to my satisfaction. I understand that I am responsible for all fees and/or balances due and agree to pay them in a timely manner in order to avoid any additional charges. I, the undersigned (patient or legally responsible party) hereby assume all financial responsibilities for treatment rendered. Furthermore, I authorize release of any information relating to my insurance claims and the assignment of any and all dental benefits paid directly to Bielozer Family Dental. I understand that I am responsible for all costs of dental treatment and any additional costs incurred in collecting this account, including interests, court cost and attorney fees, which may be added to my balance. ***I agree to the above policies and charges*****.**

X_____ Date_____

Signature of patient or responsible person

Name of patient_____

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Bielozer FAMILY DENTAL

Patient Name_____

Birthdate _____

CONSENT FOR SERVICES, APPOINTMENT AND PAYMENT POLICIES

Bielozer Family Dental is happy to take care of your dental needs. Please help us by following our appointment and payment policies.

Office Surveillance

Please be advised that all activities within the office are under continuous audio and visual surveillance and recording. We adhere to all HIPAA guidelines as related to these recordings and all office records.

Payment is due at the time of treatment

Payment for treatment is due in full at the time of treatment, unless you have made other payment arrangements with us. If we are filing an insurance claim for you, please read the next section for an explanation of payment arrangements. However, payment is due at the time of service for the Initial Emergency or Limited appointments.

Insurance claims

If we file an insurance claim for you, you will need to pay us at the time of treatment the expected estimated insurance deductible and any estimated amount that we expect insurance will not cover.

We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits.

Your Right - Copy and/or Transfer of your Records

You have the right to inspect and copy your health information and related records, by filling out our release authorization form, records will be sent within 10 days of the receipt of your written request.

Returned checks

Please take every precaution to avoid giving us a bad check. It is time consuming for our staff to deal with returned checks and this takes away from the more important job of providing dental services. For this reason, we charge $30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

Interest on late payments

Please pay your charges on time. We rely on prompt payment from our patients and their insurance companies. We will charge your account interest at the rate of 1.5% per month (18% annually) for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

Collection costs

We will charge your account for our collection costs if we refer your account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs. For a referred account that is collected prior to the start of a collection lawsuit, we will add 43% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.

Regarding Minors in the office

Minors MUST ALWAYS be accompanied by an adult; the adult accompanying a minor will be responsible for payment of services on their appointment. If the parent is giving authorization for a Caregiver, the permission form needs to be completed prior to their visit.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims. I agree to the above policies and charges.

X _____Date_____

Signature of patient or responsible person

Name of patient_____

Name of person responsible for patient charges, if different_____

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Bielozer FAMILY DENTAL

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient name:_____ Birthdate:____ /_____ /_____

I have received either a paper or an electronic copy of the HIPAA Notice of Privacy Practices for Bielozer Family Dental. I understand that I am entitled to receive a paper copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

X _____ Date signed:_____

Signature of patient, guardian, or personal representative

If applicable:

Patient's Guardian or Representative's name: _____ Phone:_____

Representative's relationship to patient:_____

Representative's address:_____

Permission To Discuss Treatment Or Billing Information

I give my permission to discuss my treatment and or billing information with:_____ Relationship to patient: _____

APPOINTMENT REMINDERS

We will remind you of upcoming appointments by phone, text and e-mail messages. Please make sure that we have your current cell phone numbers or email addresses for your reminders.

Cell phone number _____

Email address _____

For office use only:

Please complete the following only if the acknowledgment section above has not been signed by the patient or the patient's personal representative; We made a good faith effort to obtain a written Acknowledgment of Receipt of Notice of Privacy Practices, but an acknowledgment could not be obtained because *(please check one or more as appropriate)*:

_____ The patient or the patient's personal representative refused to sign
_____ A communication barrier prevented us from obtaining an acknowledgment.
_____ An emergency situation prevented us from obtaining an acknowledgment.
_____ Other (please explain)_____

Completed by:_____ Position:_____

Staff member's initials: _____ Date completed:_____

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Our initial notice was effective February 10, 2020.

HIPAA Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

(PATIENT COPY: PLEASE RETAIN FOR YOUR RECORDS; Reviewed February 2020)

Who Will Follow This Notice

This notice describes the privacy practices of Bielozer Family Dental, located in North Olmsted, Ohio. These privacy practices apply to our dental practice and to our staff, including our dentists, hygienists and other health care professionals, and employees working at our offices.

Our Pledge Regarding Health Information

We understand that medical information about you and your health is personal. We are committed to protecting your health information. We create a record of the care and services you receive at our offices. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or kept by our dentists, hygienists and other staff.

This notice will tell you about the ways we may use and disclose your health information. We also describe your rights and certain obligations we have concerning the use and disclosure of your health information.

We are required by law to:

Make sure that health information that identifies you is kept private;
Give you this notice of our legal duties and privacy practices with respect to health information about you; and
follow the terms of this notice that is currently in effect, as we may change it from time to time.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use your health information to provide you with dental treatment or services. We may disclose health information about you to dentists, dental assistants, hygienists, other dental office personnel or other health care providers who are involved in your treatment or care. For example, your dentist may need to disclose some of your health information to order tests or lab work to be performed at an outside laboratory or other outside health care provider, or your dentist may need to disclose your health information to people outside the office who may be involved in your dental or health care after you leave the dental office, such as family members, or clergy.

For Payment: We may use and disclose health information about your treatment and services to bill and collect from you, your insurance company or a third party payer. For example, we may need to give your dental/health insurance plan information so that it will pay us or reimburse you for dental services. We may also tell your health insurance plan about a treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: We may use and disclose your health information for office operations. These uses and disclosures are necessary to run our dental office and make sure that all of our patients receive quality care. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent dentists who are members of our staff, but are not employees of the office. We may also combine health information about many of our patients to decide what additional services we should offer and what services are not needed. We may also disclose information to dentists, hygienists, dental assistants and other office personnel for review and learning purposes. We may also combine the health information we have with health information from other dental practices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment at our office.

Treatment Alternatives: We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to a member of your family, your friend or another individual who is directly involved in your care and the disclosure is necessary for your welfare. The practice will limit the health information disclosed to the family member, friend or other individual to health-related signs and symptoms and to information designed to help you deal with your condition or treatment, including setting and changing appointments, receiving instructions for post-visit care or picking up treatment-related items. We may also disclose a limited amount of your health information to locate you or to locate or notify your family member or friend. We may also give information to someone who helps pay for your care. We will not make these disclosures to your friends and family if you tell us not to.

Research. Under certain circumstances, we may use and disclose health information about you for research purposes. We generally will obtain your written authorization to use your medical information for research purposes. There may be limited circumstances when access to your information for research purposes may be allowed without your specific consent.

Business Associates: There are some services that we provide through contracts with business associates. For example, we use an outside copy service if needed to make copies of your x-rays. When these services are contracted, we may disclose your health care information to our business associate so that the associate can perform the job we have asked the associate to do. To protect your health information, we require the business associate to safeguard the privacy of your information.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

To Avoid 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. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Workers' Compensation: We may release your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Your written authorization to this release is required, however, if you do not consent to a release of information, your workers' compensation benefits may be denied and you will be responsible for the costs of your dental care.

Public Health Risks: We may disclose your health information for public health activities. These activities generally include the following:

prevention or control of disease, injury or disability,
reporting births and deaths,
reporting abuse or neglect of children, elders and dependent adults,
reporting reactions to medications or problems with products,
notifying people of recalls of products they may be using or
notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations inspections and licensure. These activities are necessary for the government 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. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

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,
To identify or locate a suspect, fugitive, material witness or missing person,
About the victim of a crime if, under certain limited circumstances, we are unable to obtain the persons' agreement,
About a death we believe may be the result of criminal conduct,
About criminal conduct at the hospital and
In emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

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. We may also release health information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counter intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official if the release would be necessary for the institution to provide you with health care, to protect your health and safety and the health and safety of others or for the safety and security of the correctional institution.

Permission from you: Other uses and disclosures of health information not covered in the above categories will be made only with your permission. You may give permission with a written consent or authorization. If you provide us permission to use or disclose health information about you, you may revoke that permission at any time orally or in writing. If you revoke your permission, we will no longer use or disclose health information about you to the extent your permission is needed for the use or disclosure. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provide to you.

Your Health Information Rights

You have the following rights concerning health information we maintain about you:

Right to Inspect and Copy your Health Information: You have the right to inspect and copy your health information and to receive a written summary or explanation of your health information if you make a request in writing by completing our records authorization form and you will be provided the information and copy of records within 72 hours after the administrative fee and authorization form are completed. If you want to inspect, copy or receive this information, please contact the privacy officer listed at the end of this notice to obtain and complete the required form. If you request a copy of your health information, we will charge you a fee for the costs of copying, mailing, compiling and/or printing your request or of preparing a written summary or explanation, as well as for administrative fee that will cover labor costs. We may deny your request in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Receive your Health Information in Electronic Form: If you make a request on or after February 17, 2010, for an electronic copy of health information that we maintain in electronic form, we will provide the information in electronic form to you or directly to a third party of your choice. For providing an electronic copy of your health information, we will charge you our labor costs in responding to your request.

Right to Ask for Changes in Health Information: If you feel that health information we have about you is incorrect or incomplete, you may ask us to change or add to the information. You have the right to ask for a change or addition for as long as the information is kept by the office. You should contact the privacy officer listed at the end of this notice to get the form you will need to ask for a change or addition. You must give us a reason for your request. We may deny your request for a change or addition to your health information if it is not in writing or does not include an appropriate reason to support the request. In addition, we may deny your request if you ask us to change or add to information that:

we did not create, unless the person or entity that created the information is no longer available to make the change or addition,
is not part of the health information kept by the office,
is not part of the information which you would be permitted to inspect and copy or
is already 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 your health information except for: disclosures made to carry out treatment, payment or health care operations, disclosures to you, disclosures made pursuant to your authorizations, disclosures to persons involved in your care and certain other special disclosures described in federal regulations. To ask for this list of disclosures, you should contact the privacy officer listed at the end of this notice to get the form you will need to fill out for this purpose. Your request must state a time period, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, 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 your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny your request. We do not have to agree to the restrictions that you request, but if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you should contact the privacy officer at the address or number listed at the end of this notice to get the form you will need to fill out for this purpose. In your request, you must tell us:

what information you want to limit,
whether you want to limit our use, disclosure or both and
to whom you want the limits to apply (for example, your spouse, your children, your parents or other involved in your care).

To be binding on us, any agreement to comply with special restrictions must be in writing signed by the privacy officer for our office.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information 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 must make your request in writing to the privacy officer listed at the end of this notice. 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 this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the privacy officer listed at the end of this notice or ask any of our staff members.

Right to be Notified if Breach of Security: You have the right to be notified if there is a breach of security with respect to your protected health information. In the event of such a breach, we will notify you directly in writing or, if your contact information is out of date, we will take steps to notify you by other means, such as a posting to our web site or notices in print or broadcast media.

Changes to this Notice

We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. The current notice will be posted in our dental offices and will include the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our dental office or with the Secretary of the Department of Health and Human Services. To file a complaint, contact the privacy officer listed at the end of this notice or ask any of our staff members. All complaints must be submitted in writing. You will not be penalized for filing a complaint

Privacy Officer and Contact Information

Dr. Kacy Bielozer
Mailing address: 29732 North Olmsted, OH 44070, (440) 771 2777

Bielozer FAMILY DENTAL

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