Welcome to Dr. Denise Cohen – Pediatric Dentistry

Today's Date:______________________

How did you hear about us?____

Child's Name:________________________________Birthdate:___________________Sex:_____Age:___

Child's Nickname:_____________________________School:_______________Hobbies:_____________

Home Address:____

Home Phone Number:__________________________Names of Siblings:___________________________

Emergency Contact Name and Number:____

Previous Dentist and date of last visit (if applicable):____

Parent/Guardian #1

Name:____Do you have legal custody of this child? Y N

Birthdate:_____________________________SSN: (if insurance holder):___________________________

Cellphone number:__________________________Email Address:_________________________________

Address (if different than child's):____

Parent/Guardian #2

Name:____Do you have legal custody of this child? Y N

Birthdate:_____________________________SSN: (if insurance holder):___________________________

Cellphone number:__________________________Email Address:_________________________________

Address (if different than child's):____

Dental Insurance Company Name:______________________________ID Number:___________________

Name of parent/guardian who the insurance is under:____

Signature of release to assign insurance benefits and payments to our office:__________________________

Child's Physician's Name:_____________________________________Are immunzations up to date? Y N

Please list any health problems, or behavioral or sensory issues:____________________________________

____

Please list any previous surgical procedures:____

Please list all medications/vitamins child takes:____

Please list anything child is allergic to:____

Please list any specific dental concerns:____

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

How we may use and disclose health information about you:

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI 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 instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information request.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI 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 disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation of how payments with be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Official Name and Contact Information:

Dr. Denise Cohen-Kronfeld, DMD, PLLC, 1049 Broadway, Woodmere, NY 11598, www.DrDeniseCohen.com, (516) 459-8828

CHILD/REN'S NAME/S:____

PARENT OR GUARDIAN NAME:______________________ SIGNATURE:______________________ DATE:________

Denise Cohen-Kronfeld, D.M.D., PLLC
1049 Broadway
Woodmere, NY 11598

Office Financial Policy

In developing treatment plans for our patients we are guided by the current standard of care within the dental profession and by our own high standards of ethics and moral responsibilities to our patients. Our responsibility is to provide you with the highest quality of care, using the latest concepts and techniques in a clean, safe environment. In order to achieve this goal, we need your assistance and complete understanding of our financial policy. You are ultimately financially responsible for the professional services provided.

FULL PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

For your convenience, we accept cash, checks, and all major credit and debit cards.

Insurance

Our office is committed to helping you maximize your insurance benefits. Dental insurance is meant to be an aid in receiving dental care, and does not always cover the full cost of treatment. Because insurance policies vary, we can only estimate your coverage in good faith but *cannot* guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for you.

Cancellations

Your scheduled appointment time has been reserved specifically for you. We request 48-hours notice if you need to cancel your appointment. A charge of $50 is assessed for each "no show" or appointment cancelled with less than 48-hours notice.

Returned Checks

Checks returned from your bank unpaid are subject to a $35.00 processing charge

Outstanding Bills

Balances that are beyond 30 days past due are subject to a $10.00 monthly fee, unless other arrangements have been made in advance

Payment Plans

As a courtesy, we offer payment plans for families who need financial assistance. Your credit card will be charged the amount agreed upon by you and our office on the mutually agreed upon date.
Delinquent payment plans will be charged a $50 per month fee.

I have read and understand the above financial policy and agree to abide by it.

Patient/Legal Guardian____Date____________________

Photography Consent

I authorize Dr. Denise Cohen/Dr. Denise Cohen-Kronfeld, D.M.D., PLLC, to take photographs of myself and/or my child. I understand that the photographs may be used as a record of my child's care, and may be used for educational purposes in lectures, demonstrations to other patients, and professional publications. Further, these photos may be used in marketing efforts to include publications, websites, Facebook, Instagram, and other social media outlets.

I further understand that neither myself nor my child will receive any sort of compensation for the use of these photos.

Parent/Guardian's Initials: ______________________

Authorization to Use Testimonial Remarks

I authorize Dr. Denise Cohen/Dr. Denise Cohen-Kronfeld, D.M.D., PLLC, to use the testimonial remarks that I have provided for use in publications, websites, and social media outlets (such as Facebook and Instagram, among others) or as part of demonstrations, marketing efforts, or lectures.

I further authorize the use of my first name and my last name initial, as well as the town in which I live (e.g. Jane D., Woodmere, NY) to identify me as the source of this testimonial. If I include my child's first name in the testimonial, I authorize the use of my child's first name for the purpose of directly quoting the testimonial which I have written.

Parent/Guardian's Initials: ______________________

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Child/ren's Name/s

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Parent/Guardian's Name Parent's Signature Date