SIA N. HERSINI, D.M.D., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

_____ Phone: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations as outlined in the Uses and Disclosures Section of our Notice of Privacy Practices printed on the back of this page.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. **** A copy of our Notice accompanies this Consent on the Back of this Page***. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**** You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time from a member of the front office staff or by contacting:***

Contact Person: Sia N. Hersini DMD *Address*: 324 West North Street, Suite 6, Geneva, New York 14456 *Telephone*: 315-789-9054 *Fax*: 315-781-1297

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: CONSENT GIVEN OR SIGNED BY A PERSONAL REPRESENTATIVE MUST COMPLETE THE FOLLOWING

I represent that I am a party who may lawfully authorize this action on behalf of the above listed patient.

Signature: _____ Print Name: _____

Phone: _____ Address: _____

Relationship: _____ _____

SECTION D: SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving consent to your use and disclosure of (my / the patient's) protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

(IF YOU WOULD LIKE A COPY OF THIS CONSENT AFTER YOU SIGN IT, PLEASE ASK A MEMBER OF THE FRONT OFFICE STAFF.)

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations. I understand that revocation of my Consent will *not* affect any action taken in reliance on my Consent before receipt of this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

_____ _____

For Office Use Only

We attempted to obtain written Consent for Use and Disclosure of Health Information or Acknowledgement of Receipt of Notice of Privacy Practices, but neither could be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the consent or acknowledgement
- ☐ An emergency situation prevented us from obtaining consent or acknowledgement
- ☐ Other (Please Specify) _____

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 6, 2003, replacing a former Notice of April 14, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, health care operations, and as required by law. For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations:

Appointment Reminders: We may use or disclose your health information to provide you with appointment remainders (such as answering machines, voicemail messages, postcards, or letters).

Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, treatment notes or other similar forms of health information.

Office Operations: We may use and disclose your health information in connection with our office operations. Office operations include the functioning of employees and the ability of staff to carry out their job duties in providing health care services to the patient; it also includes quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Required by Law: We may use or disclose your health information when we are required to do so by law, which may include but is not limited to:

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Your Authorization: In addition to our use of your health information for treatment, payment, health care operations, or as required by law, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restriction on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 you disagree with a decisions 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.

Contact Person: Sia N Hersini DMD
Address: 324 West North Street, Suite 6, Geneva, New York 14456
Telephone: 315-789-9054
Fax: 315-781-1297

SIA N. HERSINI, DMD, PC

IN OFFICE PATIENT POLICY

(TO BE SIGNED PRIOR TO ADMITTANCE)

Be advised that when any dental insurance changes or updates occur to any account with this office it is the responsibility of the individual to inform us immediately of the changes. If this office is not informed of any changes to the account by the time of the next office visit, we may be unable to see the scheduled patient depending upon the dental insurance circumstances.

If an account accumulates two (2) broken appointments we generally dismiss the account. A broken appointment is an appointment that was missed without informing this office of the impending absence. We ***MUST*** be advised of a cancellation at least ***24 hours*** in advance to avoid a broken appointment.

I, the undersigned certify that I have read and understand the policies of this office and agree to follow them to the best of my ability.

Responsible Party	Relationship to Patient	Date

DENTAL ACCOUNT REGISTRATION

SIA N. HERSINI, D.M.D., P.C.

324 WEST NORTH STREET, SUITE 6 GENEVA, NEW YORK 14456
Telephone: (315) 789-9054

Date: _____ Patient's Home Phone: _____

PATIENT INFORMATION

Patient Name :(Last)_____(First)_____(M.I.)_____Soc. Sec. #_____

Address_____City_____State_____Zip_____

Sex ☐M ☐F Age_____Birthdate_____ ☐ Single ☐ Married ☐ Separated ☐ Divorced

Patient Employed By_____Occupation_____

Business Address_____City_____State_____Zip_____

Business Phone_____ Phone# of Close Friend or Relative (cannot be same as patient's #)_____

PRIMARY INSURANCE

Insurance Company_____Policy/Benefits #_____

Name of Insurance Holder:(Last)_____(First)_____(M.I.)_____

Birthdate_____Soc. Sec. #_____Relation to Patient_____

Address_____City_____State_____Zip_____

Insurance Holder's Employer_____Occupation_____

Business Address_____City_____State_____Zip_____

Home Phone_____Business Phone_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No Insurance Co._____Policy/Benefits #_____

Name of Insurance Holder:(Last)_____(First)_____(M.I.)_____

Birthdate_____Soc. Sec. #_____Relation to Patient_____

Insurance Holder's Employer_____Occupation_____

Business Address_____City_____State_____Zip_____

Home Phone_____Business Phone_____

ACCOUNT HOLDER

Adult Responsible for Account:(Last)_____(First)_____(M.I.)_____

Address_____City_____State_____Zip_____

Birthdate_____Soc. Sec. #_____Relation to Patient_____

Home Phone_____Business Phone_____

- I understand that I, as account holder, am personally and financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

- **If the insurance holder is not also the account holder, the account holder must sign the following paragraph:**

I, the undersigned account holder, certify that I am authorized to act as an agent on behalf of the insurance holder and have the authority to bind the insurance holder with respect to the assignment of insurance benefits.

Signature_____Date_____

I, the undersigned insurance holder or authorized agent, certify that the above-listed patient has insurance coverage with the enumerated insurance company(ies) and assign directly to Dr. Sia N. Hersini all insurance benefits, if any, otherwise payable to the insurance holder for services rendered. I hereby authorize the doctor and this office to release all information necessary to secure the payment of benefits, and also authorize the use of this signature toward that purpose.

Signature_____Date_____

HEALTH HISTORY

(Confidential)

DENTAL HISTORY

Reason for Today's Visit:_____ Date of last dental care:_____

Former Dentist:_____ Date of last dental X-Rays:_____

Former Dentist's Address:_____ Telephone:_____

City_____State_____Zip_____

Check (X) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name:_____Date of Last Visit:_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have had any serious illnesses or operations?_____ If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates:_____

(For Women Only) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (X) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS AND ALLERGIES

List medications you are currently taking: _____

_____

Pharmacy Name_____Pharmacy Telephone:_____

Check (X) if you are *ALLERGIC* to any of the following medications:

☐ Aspirin	☐ Penicillin	☐ Barbiturates (Sleeping Pills)	☐ Sulfa
☐ Codeine	☐ Latex	☐ Local Anesthetic	☐ Other_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any employee of Sia N. Hersini, D.M.D., P.C. responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____Date:_____

Patient Screening Form

Patient Name:

	Pre-Appointment	In-Office
	Date:	Date:
Do you/they have a fever or have you/they felt hot or feverish recently? (14-21 days)	☐Yes ☐No	☐Yes ☐No
Are you/they having shortness of breath or other difficulties breathing?	☐Yes ☐No	☐Yes ☐No
Do you/they have a cough?	☐Yes ☐No	☐Yes ☐No
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐Yes ☐No	☐Yes ☐No
Have you/they experienced recent loss of taste or smell?	☐Yes ☐No	☐Yes ☐No
Are you/they in contact with any confirmed COVID-19 positive patients?	☐Yes ☐No	☐Yes ☐No
Is your/their age over 60?	☐Yes ☐No	☐Yes ☐No
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	☐Yes ☐No	☐Yes ☐No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐Yes ☐No	☐Yes ☐No

Signature: _____ _____ _____

Patient Guardian Date