Patient Information

Patient Name _____
Last First Middle Initial

How do you wish to be addressed? _____ Birthdate _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Child

If patient is a minor, give legal custodial parents name _____

Residence Address _____
Street City Zip

Home # _____ Work # _____ Cell # _____ Pager/Other # _____

Drivers License No. _____ Social Security No. _____

Employed by _____ Occupation _____

Business Address _____

Other family members in the practice: _____

Person to contact in case of an emergency: _____ Relationship _____

Complete Address _____ Res. Phone _____

Whom may we thank for referring you? _____

Financial Information

Person responsible for this account: _____ Relationship _____

Social Security No. _____ Phone # _____

Address (If different from above) _____

Dental Insurance: ☐ Yes ☐ No Name of Insurance Co. _____ Phone # _____

Secondary Insurance: ☐ Yes ☐ No Name of Insurance Co. _____ Phone# _____

Terms & Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement form the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements. Must be paid for at the time of services performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for pay of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months form the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request , by the Doctor and/or his staff, I agree to pay therefore, the reasonable value of the said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be bills unless objected, by me, in writing , within the time for payment thereof. Additionally, I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and all reasonable attorney fees if suit be instated hereunder.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed _____ Date: _____

Consent For Treatment

I hereby authorize and request the doctor to perform the necessary dental services and/or oral surgical procedures for the treatment and/or prevention of dental disease and to do whatever procedures that judgment may dictate during the treatment.

I also authorize and request the permanent doctors to sign my name on the insurance forms if I am not able to sign them after the dental services are rendered.

Signature _____ Date: _____ Relationship: _____

Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally incompetent.

Please Complete Both Sides!

Patient Medical History

Physician Name_____ Office Phone No._____ Date of last exam_____

1. Are you under the care of a physician now?..... ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness?..... ☐ Yes ☐ No
   If yes what for?_____
   Date:_____
3. Have you ever taken Fen Phen?..... ☐ Yes ☐ No
4. Have you ever been advised not to take a particular medication?..... ☐ Yes ☐ No
   If yes, please list:_____
5. Have you been advised to take prophylactic antibiotics before dental treatment?..... ☐ Yes ☐ No
6. Please list all medications you are currently taking:

Name/Mg	Purpose	Frequency	Since

7. Are you allergic or have had any reactions to any of the following?

Local Anesthetics (e.g. Novocaine/Xylocaine)...	☐ Yes	☐ No
Penicillin or other Antibiotics.....	☐ Yes	☐ No
Sulfa Drugs.....	☐ Yes	☐ No
Barbiturates.....	☐ Yes	☐ No
Sedatives.....	☐ Yes	☐ No
Iodine.....	☐ Yes	☐ No
Aspirin.....	☐ Yes	☐ No
Latex allergy.....	☐ Yes	☐ No
Nitrous Oxide.....	☐ Yes	☐ No
Epinephrine.....	☐ Yes	☐ No
Sleeping Pills.....	☐ Yes	☐ No
Codeine.....	☐ Yes	☐ No

Other (Please List)_____

8. Do you consume alcohol ?..... ☐ Yes ☐ No
   # of drinks per day:_____
   Do you use Tobacco?..... ☐ Yes ☐ No
   Approximately packs per day:_____
   For how many years_____
   Do you use any recreational drugs such as cocaine, marijuana, stimulants or depressants which may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidently with the doctor. ☐ Yes ☐ No
9. Women Only
   A) Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
   B) Are you nursing?..... ☐ Yes ☐ No
   C) Are you taking birth control pills?..... ☐ Yes ☐ No
10. Do you have heart trouble or any form of cardiovascular disease? ☐ Yes ☐ No

Angina.....	☐ Yes	☐ No	Date_____
Heart Attack.....	☐ Yes	☐ No	Date_____
Heart Surgery.....	☐ Yes	☐ No	Date_____
Type_____			
Stroke.....	☐ Yes	☐ No	Date_____
Rheumatic Fever....	☐ Yes	☐ No	Date_____

Heart Murmur.....	☐ Yes	☐ No Date_____
High Blood Pressure	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Arteriosclerosis.....	☐ Yes	☐ No
Swollen Ankles.....	☐ Yes	☐ No
Heart Disease.....	☐ Yes	☐ No
Cardiac Pacemaker...	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Easily Winded.....	☐ Yes	☐ No

Other_____

11. Do you have or have you ever had any of the following?

Diabetes or Hypoglycemia.....	☐ Yes	☐ No
Kidney Disease.....	☐ Yes	☐ No
Liver Disease or Jaundice.....	☐ Yes	☐ No
Hepatitis.....	☐ Yes	☐ No
Excessive Bleeding.....	☐ Yes	☐ No
Psychiatric Problems.....	☐ Yes	☐ No
Joint Replacement or Implant.....	☐ Yes	☐ No
Hives or Skin Rash.....	☐ Yes	☐ No
Arthritis.....	☐ Yes	☐ No
Glaucoma.....	☐ Yes	☐ No
Tuberculosis.....	☐ Yes	☐ No
Emphysema or Breathing Problems.....	☐ Yes	☐ No
Stomach or Intestinal Disorders.....	☐ Yes	☐ No
Fainting Spells, Convulsions or Epilepsy	☐ Yes	☐ No
Sinus Trouble.....	☐ Yes	☐ No
Asthma or Hay Fever.....	☐ Yes	☐ No
Do you us an inhaler?.....	☐ Yes	☐ No
Thyroid Problems.....	☐ Yes	☐ No
Frequently Tired.....	☐ Yes	☐ No
Recent Weight Loss.....	☐ Yes	☐ No
Cancer.....	☐ Yes	☐ No

What Kind:_____
When Diagnosed:_____
Radiation Therapy..... ☐ Yes ☐ No
When:_____

Patient Dental History

1. Do your gums bleed while brushing and flossing?..... ☐ Yes ☐ No
2. Do you feel pain to any of your teeth?..... ☐ Yes ☐ No
3. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
4. Have you had any head, neck or jaw injuries?..... ☐ Yes ☐ No
5. Have you ever experienced any of the following problems in your jaw?
   A) Clicking ☐ Yes ☐ No
   B) Pain (joint, ear, side of face)..... ☐ Yes ☐ No
   C) Difficulty in opening or closing..... ☐ Yes ☐ No
   D) Difficulty in chewing..... ☐ Yes ☐ No
6. Do you have frequent headaches?..... ☐ Yes ☐ No
7. Do you clench or grind your teeth?..... ☐ Yes ☐ No
8. Do you bite your lips or cheeks frequently?..... ☐ Yes ☐ No
9. Have you ever had any difficult extractions in the past? ☐ Yes ☐ No
10. Have you ever had any orthodontic work?..... ☐ Yes ☐ No
11. Have you ever had any prolonged bleeding following extractions?..... ☐ Yes ☐ No
12. Do you love your smile?..... ☐ Yes ☐ No
    If no, why not?_____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. I deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation.

Date **Patients Signature(Parent or Guardian if under 18)** **Reviewed By** **B.P. / P / ASA Cl.**

_____

_____

_____

_____

ARBITRATION AGREEMENT

Article 1: AGREEMENT TO ARBITRATE

I understand that any dispute as to dental malpractice, that is as to whether any dental care and treatment rendered to patient under this agreement were unnecessary or unauthorized, or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by [insert "State"] law, and not by lawsuit or resort to court process except as [insert "State"] law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article II: ALL CLAIMS MUST BE ARBITRATED

It is the intent of the parties that this agreement binds all parties whose claims may arise out of or related to treatment or services provided by the dentist, partners, associates and agents or employees, including any spouse or heirs of the patient, born or unborN, at the time of the occurrence giving rise to any claim.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the dentist, partners, associates, and employees or agents, must be arbitrated, including, without limitation, claims for lost of consortium, wrongful death emotional distress punitive damages. filling, of any action in any court by the dentist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against, the dentist, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article III: PROCEDURES AND APPLICABLE LAW

A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed to the parties within thirty (30) days thereafter. Each party to the arbitrator shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or any entity which would otherwise by a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of (insert "State") law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, [insert appropriate state laws by Code & Section number.]

Article IV: GENERAL PROVISIONS

All claims based upon the same Incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted as a civil action, would be barred by the applicable California statute of limitations or (2) the claimant falls to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the [insert "State") Code of Civil Procedure provision relating to arbitration.

pt. initials

Article V: REVOCATION

This agreement way be revoked by written notice delivered within thirty (30) days of signature and if not revoked will govern all dental services received by the patient.

Article VI: RETROACTIVE EFFECT

If patient intend this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial below:

Effective as of the date of first medical services. _____ Pt. Initials

If any provision of this Arbitration Agreement -is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP ACCESS TO A JURY OR COURT TRIAL. See Article I of this.

Print name of Dentist, Dental Group, Association
CREATING SMILES
ROBERT A. WITEK, D.D.S., INC.

By: _____
Dentist of Duty
Authorized Representative
Date

Translated by: (if applicable)

_____
Signature
Date

_____
Print Name

A signed copy of this document is given to the patient.
Original to be filed in patient's chart.

_____
Patient Signature
Date

_____
Patient Printed Name

_____
Patient's Agent or Representative
Date

*If patient is under 18 years of age a parent or legal guardian must sign

_____
Print Name

_____
Relationship to Patient

Creating Smiles
Robert A. Witek, DDS., Inc.
31309 Temecula Pkwy, Suite 100
Temecula, CA 92592

_____ Pt. Initials

INFORMED CONSENT FORM
FOR DENTAL TREATMENT

FILLINGS

BENEFITS:
- Eliminates decay
- Relieve pain
- Fill in a hole or space in a tooth
- Cover eroded areas
- Protect a sensitive surface

POSSIBLE COMPLICATIONS:
- Tooth may abscess from deep filling
- Large fillings may fracture the tooth
- Tooth may be sensitive to temperature changes
- Toxicity from silver fillings is alleged by some
- Fillings may fall out

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- May lose the tooth
- Tooth may fracture
- Decay will get larger
- Pain will get worse
- May result in need for a root canal

ALTERNATIVES:
- Temporary filling
- Extraction

CLEANING - SCALING

BENEFITS:
- Look nicer
- Clean mouth
- Eliminate odors
- Prevents gum disease
- Some portions may be performed by auxiliary personnel

POSSIBLE COMPLICATIONS:
- Sensitive teeth
- Feeling of spaces between teeth
- Filling may be loosened (normal if filling was ready to fall out)
- Sensitive gums

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Stains on teeth
- Odors
- Gum disease
- Will lose teeth sooner

ALTERNATIVES:
- None

EXTRACTIONS

BENEFITS:
- Last resort for non-salvageable tooth
- Eliminate pain
- Remove teeth that are out of position
- Eliminate infection

POSSIBLE COMPLICATIONS
- Fractured particles may remain
- Irritation to nerves may cause temporary or permanent numbness
- Part or all of tooth may be lodged in sinus, requiring more surgery
- Bad infections may take a long time to clear up
- Jaw may be stiff and difficult to open for a time
- If jawbone is very weak, it may fracture

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Spread of infection
- Swelling
- Pain

ALTERNATIVES
- None

BONDED FACINGS

BENEFITS
- Aesthetics - they look nice
- Cover crooked teeth
- Close spaces and gaps
- Cover discolored teeth

POSSIBLE COMPLICATIONS
- Edges can stain after a time and need to be freshened up (additional fee)
- Breakage can occur, resulting in need for remake
- Difficult to remove

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- None (other than appearance)

ALTERNATIVES
- Crowns

X-RAYS

BENEFIT
- More complete diagnosis
- Can find hidden problems
- Can make a determination of treatment
- X-Rays taken by qualified personnel

POSSIBLE COMPLICATIONS
- Exposure to X-Ray radiation (minimal)
- X-Ray pictures remain the property of dental office

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Can not perform dental services
- May not diagnose all needed work

ALTERNATIVES
- None

LOCAL ANESTHETICS

BENEFITS
- Avoid pain during treatments and procedures

POSSIBLE COMPLICATIONS
- Prolonged numbness may extend beyond normal
- Nerve damage
- Bruising (hematoma)
- In rare instances, possible consequences may include:
  - those applicable to General Anesthesia, including
  - allergic reactions up to and including death
  - (separate detail information sheet is available upon request)

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Mild to severe pain during and after treatment

ALTERNATIVES
- Willingness to accept pain during treatment

CROWNS - CAPS

EFITS
Make you look nicer (cosmetic)

To prevent a tooth from fracturing
To restore a tooth which has broken
To eliminate a space where food is being trapped
To hold a false tooth in place as part of a bridge
To make a solid structure to attach a partial denture
To splint loose teeth together to strengthen them
The tooth no longer can be filled (filling to large to last)

SIBLE COMPLICATIONS
Porcelain portion of crown may fracture
Crown may come off and need to be recemented
Tooth may abscess and require further treatment (may not show up until later due to deep decay)
Future decay may require a filling or new crown

SEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
Tooth will probably fracture
Tooth may need to be extracted
May need a root canal in addition to the crown
May need bridgework or dentures

ERNATIVES
Extraction
Temporary crown
Steel crown

BRIDGEWORK

EFITS
Make you look nicer
To replace missing teeth
Missing teeth are not removable
Some of same advantages as Crowns
Can improve chewing efficiently
Keep missing teeth form drifting

SIBLE COMPLICATIONS
Same as Crowns

ISEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
Teeth will drift and lean over
May lose back teeth due to shifting
Periodontal problems (gum disease)
Can reduce chewing efficiency

ERNATIVES
Partials
Temporary partials
No teeth in the spaces

IMMEDIATE DENTURES

SIBLE COMPLICATIONS
Immediate Denture do require 2 soft relines
Hard reline 6 to 8 months after surgery
Full lower dentures if loose requires implants

PARTIALS (REMOVABLE BRIDGEWORK)

BENEFITS (less than fixed bridge)
Cost

POSSIBLE COMPLICATIONS
Can wear on teeth
Can rock or stress teeth - may loosen own natural teeth
Metal clasps are sometimes visible
Decay can occur under clasps
Usually some amount of movement from the partial

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
Same as under Bridgework

ALTERNATIVES
Bridgework
Temporary partial
Keep spaces without teeth placement

ROOT CANAL

BENEFITS
Eliminate infection
Relieve pain
Save the tooth from extraction

POSSIBLE COMPLICATIONS
Undiagnosable root fracture means failure and extractions
Undiagnosable auxiliary canal means failure and extraction
Infection

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
Extraction of tooth
Serious infection

ALTERNATIVES
Extraction
Bridgework
Partial Denture

GUM SURGERY (GINGIVECTOMY)

BENEFITS
Eliminate infection
Reduce food pockets around teeth
Eliminate foul odors
Reduce overgrown tissue
Can eliminate tartar effectively

POSSIBLE COMPLICATIONS
May need to be repeated after a time
Some after pain
Might lose teeth if they don't respond to treatment

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
Will lose teeth sooner
May not get rid of infection

ALTERNATIVES
More frequent appointments for scaling

E OF PATIENT: _____

E OF GUARDIAN: _____

.VE READ THE ABOVE STATEMENTS AND HAVE RECEIVED A COPY OF THEM, RECOGNIZE AND UNDERSTAND THEIR IMPORTANCE IN .PING ME MAKE DECISIONS. I RECOGNIZE AND UNDERSTAND THAT FAILURES CAN OCCUR FOR VARIOUS REASONS AND THAT .MPLICATIONS CAN OCCUR IN ANY PROCEDURE. I ALSO UNDERSTAND THAT WHERE DECAY HAS OCCURRED, OR A TOOTH HAS .CTURED OR ABSCESSED, THESE SAME FORCES ARE STILL WORKING ON THE TOOTH EVEN AFTER IS HAS BEEN RESTORED; THEREFORE, :AY OR FRACTURE CAN STILL OCCUR AS THE RESTORED TOOTH IS NO BETTER THAN WHAT NATURE HAS GIVEN IN THE FIRST PLACE. IN)ER TO RECEIVE TREATMENT, I CONTRACT THAT IF THERE IS ANY DIFFERENCES OR DISAGREEMENTS BETWEEN MY ATTENDING DENTIST) MYSELF, I WILL FIRST PRESENT SUCH DIFFERENCE OR DISAGREEMENT TO MY ATTENDING DENTIST IN ORDER TO RESOLVE THE)BLEM. IF WE ARE UNABLE TO AGREE ON A SOLUTION, THEN I AGREE TO TAKE THE PROBLEM TO A RECONCILIATION BOARD SUCH AS : DENTAL SOCIETY OF CALIFORNIA STATE CONSUMER AFFAIRS BOARD OF DENTAL EXAMINERS AND AGREE TO ACCEPT THEIR :OLUTION IN LIEU OF PURSUING REMEDIES BY WAY OF LITIGATION. IN CONSIDERATION OF HELPING TO KEEP COSTS OF TREATMENT AND .VICES AS LOW AS POSSIBLE, I ALSO UNDERSTAND THAT THIS AGREEMENT IS BINDING ON MY HEIRS AND ALL OTHER FAMILY MEMBERS.

_____ SIGNATURE _____ DATE

CREATING SMILES
ROBERT A. WITEK, D.D.S., INC.

{NAME OF PRACTICE}

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 04/14/03, 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, and healthcare operations. For example:

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

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

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.

To 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 healthcare or with payment for your healthcare, but only if you agree that we may do so.

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. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. 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 healthcare. 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, or other similar forms of health information.

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

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

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.

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

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 expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.__*__ for each page, $__*__ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a 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.)

* COPY OF YOUR DOCUMENTS MAY BE A $25.00 CHARGE.

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, healthcare 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 restrictions 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 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.

Contact Officer: Dr. Robert Witek

Telephone: 951 302-9800 Fax: 951 302-6012

E-mail: rwitek5@yahoo.com

Address: 31309 Temecula PKwy. Suite 100
Temecula, Ca 92592

CREATING SMILES
ROBERT A. WITEK, D.D.S., INC.

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

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

_____

_____

_____

CREATING SMILES
ROBERT A. WITEK, D.D.S., INC.

{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

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 healthcare operations.

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 healthcare 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. 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 by contacting:

Contact Person: _____

Telephone: 951 302-9800 Fax: 951 302-6012

E-mail: rwitek5@yahoo.com

Address: 31309 Temecula Pkwy Suite 100, Temecula CA 92592

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.

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 my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received 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.

Signature: _____ Date: _____ _____

Creating Smiles Dental Office
Robert A. Witek, D.D.S., Inc

Payment Policy

Full payment for service rendered is expected at the time services are provided for all cash and non-insured patients. Co-payment and deductibles are also due at the time services are provided for those insured patients.

We will do our best in getting your benefits and co-payment information from your insurance company; however, we are relying on insurance information given to us over the phone and per the insurance company quotes, "this is not a guarantee of payment" from them.

You will be billed for any amount not paid by your insurance company. We will send you a statement as soon as possible, but keep in mind it takes 2-4 months (or longer) to get payment from your insurance company.

If you need to make payment arrangements please do so prior to your treatment being done. Our office accepts cash, checks, Visa, Master Card, Discover, Care Credit and Health Care Credit.

We can help you apply for Care Credit and Health Care Credit right here in our office.

By submitting your check for payment, you are authorizing the payee, or its agent, upon receipt of your check, to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

Cancellation Policy

This office requires 24hr notice if you have to cancel or reschedule any appointment. Failure to do so may result in a $50 charge on your account. This fee is not covered by your insurance.

I understand the policies of the office.

_____ _____

Signature of Patient Date