ENGLEWOOD FAMILY DENTISTRY
DR. KAMLESH JETHANI
214 ENGLE ST., ENGLEWOOD NJ 07631
TEL: (201) 567-4141

HIPAA PRIVACY POLICY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION.

Health Insurance Portability Accountability Act (HIPAA), 1996 http://www.hhs.gov/ocr/hipaa/final/reg.html

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 other important matters about your protected health information. 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 applied 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: Englewood Family Dentistry, 214 Engle Street #24, Englewood, NJ 07631, (201)657-4141 www.englewoodfamilydentistry.com

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

CONSENT TO RELEASE RECORDS, PROCESS INSURANCE AND BILL PATIENT ACCORDINGLY:

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize Englewood Family Dentistry and its Associates to release any information including the diagnosis and records of treatment and examination for myself and my dependent(s) to third-party insurance carriers, payors and/or healthcare practitioners. I authorize Englewood Family Dentistry and its Associates to submit any claims electronically or by standard mail, and/or transfer any records or share any records with other health care providers electronically or by standard mail. I authorize the payment from my insurance carrier to submit payment directly to Englewood Family Dentistry and its Associates and for payments to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I

have been advised that is my responsibility to understand my insurance coverage, including provisions of my policy, maximums, deductibles, and excluded procedures. Englewood Family Dentistry may assist in explaining such coverage, but ultimately, it is my sole responsibility to be educated on my policy.

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.

ACKNOWLEDGEMENT OF RECEIPT:

This form is used to obtain acknowledgement that you have been notified that our NOTICE OF PRACTICE POLICIES can be obtain via our office.

Signature of patient, parent, or guardian (responsible party)

Signature: _____ Date: _____