



WELCOME TO OUR PRACTICE

On behalf of the entire team at Kondorossy Dental Art & Implant Center, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at KondorossyDental.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Coloman E. Kondorossy, DMD, FAGD, DICOI
Stephen K. Kondorossy, DMD, MBS

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PATIENT REGISTRATION

Welcome to our office. Please be kind enough to answer the following questions. Thank you so much for being our guest!

Name (Last)	(First)	(Middle)	Date of Birth	M F	S M D W	Sex	Marital Status	Social Security Number
How would you like to be addressed?			Email Address			Cell Phone Number		
Home Address (Street)		(City)	(State)	(ZIP Code)		Home Phone Number		
Name of Employer			Occupation			Driver's License Number		
Business Address (Street)		(City)	(State)	(ZIP Code)		Business Phone Number		

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for account? self spouse parent/guardian other
 (Please fill in the following information if the person responsible is different from self.)

Name (Last)	(First)	(Middle)				Social Security Number
Home Address (Street)		(City)	(State)	(ZIP Code)		Home Phone Number
Name of Employer			Occupation			Business Phone Number

INSURANCE INFORMATION

Insured Member (Last)	(First)	(Middle)	Relationship	SSN	Date of Birth	
Name of Employer			Occupation		Business Phone Number	
Business Address (Street)		(City)	(State)	(ZIP Code)		Dental Insurance Co.
Group Number _____			ID Number _____			

What are your hobbies? Special interests? _____
 How did you hear of our office? _____

If patient was assisted with this form, enter name of person assisting:

Print name	Sign name	Date
Signature of patient		Date

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT GOOD FAIR POOR Name of physician _____
Physician's Address _____ Telephone Number _____ Date of Last Physical _____

Are you now under the care of a physician? Yes No

Are you pregnant or do you think you may be pregnant? Yes No If yes, expected delivery date: _____

Are you nursing?.....Yes No

Are you taking birth control pills? Yes No

Do you smoke?Yes No If yes, how much? _____

Are you taking any medication now? Yes No If yes, names of medications and problems for which they are taken:

Medication 1) _____ Taken for _____ 3) _____ Taken For _____

2) _____ Taken for _____ 4) _____ Taken For _____

Do you use tobacco?.....Yes No

Have you ever taken Fen-Phen or Redux?.....Yes No

Have you ever required a blood transfusion?.....Yes No

Are you wearing contact lenses?.....Yes No

Do you or have you used controlled substances?.....Yes No

Do you bruise easily?.....Yes No

Have you ever had (please check-mark appropriate boxes):

Abnormal blood pressure.....High Low No

Heart surgery.....Yes No

AIDS/HIV.....Yes No

Hepatitis.....Yes No

Anemia.....Yes No

Jaundice.....Yes No

Arthritis.....Yes No

Joint replacement or implant.....Yes No

Asthma or hay fever.....Yes No

Kidney trouble.....Yes No

Allergies.....Yes No

Mental health care.....Yes No

Back problems.....Yes No

Lymph node enlargement (swollen glands).....Yes No

Cancer.....Yes No

Mitral valve prolapse.....Yes No

Chemical dependency.....Yes No

Night sweats.....Yes No

Cold sores/Fever blisters.....Yes No

Pacemaker.....Yes No

Common cold.....Yes No

Persistent diarrhea.....Yes No

Congenital heart lesions.....Yes No

Prolonged bleeding.....Yes No

Diabetes.....Yes No

Rheumatic fever.....Yes No

Drastic weight loss.....Yes No

Sexually transmitted disease.....Yes No

Eating disorders.....Yes No

Sinus trouble.....Yes No

Epilepsy/Seizures.....Yes No

Swollen ankles.....Yes No

Excessive urination and/or thirst.....Yes No

Stroke.....Yes No

Fainting spells.....Yes No

Thyroid problem.....Yes No

Glaucoma.....Yes No

Tuberculosis or lung disease.....Yes No

Heart disease.....Yes No

Ulcers.....Yes No

Heart murmur.....Yes No

X-ray treatments for cancer.....Yes No

If you have entered "yes" to any of the above, please explain: _____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocaine.....Yes No

Aspirin.....Yes No

Penicillin or other antibiotics.....Yes No

Iodine.....Yes No

Sulfa drugs.....Yes No

Any metal (e.g. gold, nickel, etc.).....Yes No

Barbiturates, sedatives, or sleeping pills.....Yes No

Latex/Rubber.....Yes No

Codeine.....Yes No

Tylenol.....Yes No

Other (please list) _____

Have you had any other serious illness, hospitalization, or accident? _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release Kondorossy Dental Art & Implant Center to utilize any dental photographs for lecturing and educational purposes.

Signature: _____ Date: _____

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?..... Yes No

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

Do you have missing teeth?_____ If yes, have you had them replaced?_____

If you have had missing teeth replaced, are you happy with the results? _____

If not, would you like to learn about your options to replace them? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth?_____ How often do you floss? _____ What type of brush do you use? Manual Powered

Do you avoid brushing any part of your mouth because of pain? Yes No If yes, what part? _____

Which foods cause you twinges of pain: hot cold sweet sour none Do you lose fillings or break fillings?..... Yes No

Do you chew on only one side of your mouth?.....Yes No If yes, explain: _____

Do your gums feel tender or swollen?.....Yes No Do you usually have many cavities?.....Yes No

Do you clench or grind your jaws while sleeping or during the day?.....Yes No Do your jaws ever feel tired?.....Yes No

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
- Spreading payments out over time may help me to achieve the excellent results I desire.
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)_____

Would you like to have whiter teeth? Yes No

If you had a magic wand, what, if anything, would you change about your smile?_____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight... Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes No If yes, please check off all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important: _____

At Kondorossy Dental Art & Implant Center, though our focus is on appearance-related dentistry, our team also delivers routine general dental care. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.
Which would you prefer? Tylenol Advil Other _____

- We provide various levels of sedation to ease your mind.
Would you benefit from a sedative?.....Yes No

If yes, we provide: Nitrous Oxide (laughing gas)
 Mild sedative (oral medication) With mild sedative, you will need someone to drive you to and pick you up from the appointment.

- Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

- Blankets help keep you warm and relaxed through your visit.
Would you like a blanket?.....Yes No

- Pillows provide an extra measure of comfort if you have a sore back or neck.
Would you like a pillow?.....Yes No

- We also offer our patients a complimentary hot towelette after your visit.
Would you like to take advantage of this service?.....Yes No

- Is there anything else we can do for you to make your visit comfortable?

YOUR DENTAL NEEDS

Your Name: _____ Date: _____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never considered before. Please check what best expresses how you feel about the following questions:

• Are you having any areas of concern? _____

• What do you think is the present state of your oral health? _____

• What do you already know about our office and what are your expectations? _____

• How healthy do you want us to get your mouth? (please circle)

The best it can be Average Don't really care

• Should you need treatment, at what point should we address it? (please circle)

When something isn't ideal When something is worsening When my tooth hurts or breaks

• What quality of dentistry do you want us to recommend? (please circle)

Ideal/the best Average Just patch it

• We have the ability to look at your mouth from three different perspectives. Please rank these in the order of most important to least important to you.

___ As a general dentist ___ As a cosmetic dentist ___ As a functional dentist

• How do you feel about the appearance of your face and smile? _____

• What would it take for you to trust us to be your dentist? _____

• Tell us about your good dental experiences. _____

• And the bad ones. _____

• Has fear ever been an issue for you in a dental office? _____

• What caused you to leave your last dental office? _____

• Has time ever been a factor in getting your dental work done? _____

• Has cost of dental treatment been a concern for you? _____

• What can we do to help you with this? _____

• Is there any additional information you would like us to know? _____



APPOINTMENT AGREEMENT

At Kondorossy Dental Art & Implant Center, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a \$50 late cancellation charge.

We truly appreciate your understanding. Our goal at Kondorossy Dental Art & Implant Center is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I agree to fulfill my obligation as a patient at Kondorossy Dental Art & Implant Center and agree to the "broken appointment" fee should I not give proper notification.

Signature of patient or responsible party

Date



General Dentists

Coloman E. Kondorossy, DMD, FAGD, DICOI
Stephen K. Kondorossy, DMD, MBS

FINANCIAL POLICIES

Here at Kondorossy Dental Art & Implant Center, our office policy regarding financing is as follows: As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient/patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or money order. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of 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 as billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further 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 reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Kondorossy Dental Art & Implant Center and/or Kondorossy Dental Art & Implant Center's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party



SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS

At Kondorossy Dental Art & Implant Center, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits, but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't, we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits...

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits, please contact your employer or the benefits carrier directly.

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of \$1,000. There has been no significant increase in the yearly maximum cap in 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." A dental benefits company determines their reimbursement level by surveying a geographical area and calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that dental benefit companies define as "*higher than usual and customary.*"

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum, or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Dental benefit companies do NOT cover many routine and newer dental services.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.



INSURANCE CLAIMS PROCESS

Our office is pleased that you have insurance benefits to help you with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept all private care insurance (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?

We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to visiting our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DIDN'T PAY. NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

Our office does request payment in full for your estimated portion at the time of service. All accounts not paid in full after 60 days will be charged a finance charge at a rate of 2% per month (24% per annum). If you are in need of an extended option, please just ask one of the patient services staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at your office, Kondorossy Dental Art & Implant Center.

Name: _____ Date: _____



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ 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. 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 our office at (732) 249-0055 or by mailing us at 1445 Hamilton St., Somerset, NJ 08873.

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 address above. Please understand that revocation of this Consent will not affect any action we took 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: _____

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

1445 Hamilton St. • Somerset, NJ 08873 • (732) 249-0055

KondorossyDental.com



NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature: _____ Date: _____

Please contact us for more information:
Kondorossy Dental Art & Implant Center
1445 Hamilton St.
Somerset, NJ 08873
(732) 249-0055
KondorossyDental.com

For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 or Toll Free: 1-877-696-6775