Anthony J. Tisoncik, DDS

WELCOME TO OUR PRACTICE

On behalf of the entire team at Anthony J. Tisoncik, DDS, 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 www.PalosHillsDental.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Anthony J. Tisoncik, DDS

Anthony J. Tisoncik, DDS

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST, FIRST MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	E-MAIL

MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

SPOUSE'S NAME LAST, FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐

PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS		INSURANCE PHONE
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS		INSURANCE PHONE
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO
Health Care Providers	☐	☐
Insurance Companies	☐	☐

OTHERS (PLEASE PRINT)

1.

2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers, demonstrations and/or presentations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

MEDICAL HISTORY

Patient Name ______________________________ Nickname ______________ Age ________
Name of Physician/and their specialty ______________________________
Most recent physical examination ______________________ Purpose ______________________
What is your estimate of your general health? ▢ Excellent ▢ Good ▢ Fair ▢ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ____________	▢	▢
2.	an allergic reaction to		
	▢ aspirin, ibuprofen, acetaminophen, codeine		
	▢ penicillin		
	▢ erythromycin		
	▢ tetracycline		
	▢ sulfa		
	▢ local anesthetic		
	▢ fluoride		
	▢ metals (nickel, gold, silver, ____________)		
	▢ latex		
	▢ other ____________		
3.	heart problems, or cardiac stent within the last six months __	▢	▢
4.	history of infective endocarditis ____________	▢	▢
5.	artificial heart valve, repaired heart defect (PFO) ________	▢	▢
6.	pacemaker or implantable defibrillator ____________	▢	▢
7.	artificial prosthesis (heart valve or joints) ____________	▢	▢
8.	rheumatic or scarlet fever ____________	▢	▢
9.	high or low blood pressure ____________	▢	▢
10.	a stroke (taking blood thinners) ____________	▢	▢
11.	anemia or other blood disorder ____________	▢	▢
12.	prolonged bleeding due to a slight cut (INR > 3.5) ________	▢	▢
13.	emphysema, shortness of breath, sarcoidosis ____________	▢	▢
14.	tuberculosis, measles, chicken pox ____________	▢	▢
15.	asthma ____________	▢	▢
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	▢	▢
17.	kidney disease ____________	▢	▢
18.	liver disease ____________	▢	▢
19.	jaundice ____________	▢	▢
20.	thyroid, parathyroid disease, or calcium deficiency ________	▢	▢
21.	hormone deficiency ____________	▢	▢
22.	high cholesterol or taking statin drugs ____________	▢	▢
23.	diabetes (HbA1c =_______) ____________	▢	▢
24.	stomach or duodenal ulcer ____________	▢	▢
25.	digestive disorders (i.e. celiac disease, gastric reflux) _______	▢	▢
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) __	▢	▢
27.	arthritis, rheumatoid arthritis, lupus ____________	▢	▢
28.	glaucoma ____________	▢	▢
29.	contact lenses ____________	▢	▢
30.	head or neck injuries ____________	▢	▢
31.	epilepsy, convulsions (seizures) ____________	▢	▢
32.	neurologic disorders (ADD/ADHD, prion disease) _______	▢	▢
33.	viral infections and cold sores ____________	▢	▢
34.	any lumps or swelling in the mouth ____________	▢	▢
35.	hives, skin rash, hay fever ____________	▢	▢
36.	STI / STD ____________	▢	▢
37.	hepatitis (type ___) ____________	▢	▢
38.	HIV / AIDS ____________	▢	▢
39.	tumor, abnormal growth ____________	▢	▢
40.	radiation therapy ____________	▢	▢
41.	chemotherapy, immunosuppressive ____________	▢	▢
42.	emotional problems ____________	▢	▢
43.	psychiatric treatment ____________	▢	▢
44.	antidepressant medication ____________	▢	▢
45.	alcohol / street drug use ____________	▢	▢

ARE YOU:

		YES	NO
46.	presently being treated for any other illness ___________	▢	▢
47.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ___________	▢	▢
48.	taking medication for weight management (i.e. fen-phen)	▢	▢
49.	taking dietary supplements ____________	▢	▢
50.	often exhausted or fatigued ____________	▢	▢
51.	experiencing frequent headaches ____________	▢	▢
52.	a smoker, smoked previously or use smokeless tobacco _	▢	▢
53.	considered a touchy person ____________	▢	▢
54.	often unhappy or depressed ____________	▢	▢
55.	FEMALE - taking birth control pills ____________	▢	▢
56.	FEMALE - pregnant ____________	▢	▢
57.	MALE - prostate disorders ____________	▢	▢

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ____________

Doctor's Signature ______________________________ Date ____________

DENTAL HISTORY

Name_______________________________ Nickname______________________________ Age_________

Referred by___________________________How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _______________________________How long have you been a patient?___________Months/Years

Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______

Date of most recent treatment (other than a cleaning) ______/______/______

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ____________ ☐ ☐
2. Have you had an unfavorable dental experience? ____________ ☐ ☐
3. Have you ever had complications from past dental treatment? ____________ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ____________ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ____________ ☐ ☐
6. Have you had any teeth removed? ____________ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ____________ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ____________ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ____________ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ____________ ☐ ☐
11. Have you ever experienced gum recession? ____________ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____________ ☐ ☐
13. Have you experienced a burning sensation in your mouth? ____________ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ____________ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ____________ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ____________ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ____________ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ____________ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ____________ ☐ ☐
20. Do you frequently get food caught between any teeth? ____________ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ____________ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ____________ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____________ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ____________ ☐ ☐
25. Are your teeth crowding or developing spaces? ____________ ☐ ☐
26. Do you have more than one bite and squeeze to make your teeth fit together? ____________ ☐ ☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ____________ ☐ ☐
28. Do you clench your teeth in the daytime or make them sore? ____________ ☐ ☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? ____________ ☐ ☐
30. Do you wear or have you ever worn a bite appliance? ____________ ☐ ☐

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? ____________ ☐ ☐
32. Have you ever whitened (bleached) your teeth? ____________ ☐ ☐
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? ____________ ☐ ☐
34. Have you been disappointed with the appearance of previous dental work? ____________ ☐ ☐

Patient's Signature ______________________________________ Date______________

Doctor's Signature ______________________________________ Date ______________

Anthony J. Tisoncik, D.D.S.
General and Sleep Dentistry

◊ M ◊ F

Name ______ Gender ______ DOB ______

Address, City, State, Zip ______ Weight ______ Height ______ Neck Size ______

Cell Phone ______ Alt. Phone ______ Email ______

PPO Medical Insurance Company ______ (Non-PPO) ______ ID# ______ Group# ______

Have you ever been diagnosed with a sleep disorder? ◊ YES ◊ NO Night time oxygen use? ◊ YES ◊ NO

Are you currently using a CPAP Machine? ◊ YES ◊ NO (if YES) Do you use it every night? ◊ YES ◊ NO

Answer **"YES"** or **"NO"** to the following questions (circle Yes or No answers)

◊ Y ◊ N 8 Have you ever been told you stop breathing while asleep?
◊ Y ◊ N 6 Have you ever fallen asleep or nodded off while driving?
◊ Y ◊ N 6 Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
◊ Y ◊ N 4 Do you feel excessively sleepy during the day?
◊ Y ◊ N 4 Do you snore or have you ever been told that you snore?
◊ Y ◊ N 2 Have you had weight gain and found it difficult to lose?
◊ Y ◊ N 2 Have you taken medication for, or been diagnosed with high blood pressure?
◊ Y ◊ N 3 Do you kick or jerk your legs while sleeping?
◊ Y ◊ N 3 Do you feel burning, tingling or crawling sensations in your legs when you wake up?
◊ Y ◊ N 3 Do you wake up with headaches during the night or in the morning?
◊ Y ◊ N 4 Do you have trouble falling asleep?
◊ Y ◊ N 4 Do you have trouble staying asleep once you fall asleep?

______ **Score and Risk Factor (Add the points that you have answered "YES")**

Low 0-7	Moderate 8-11	High 12-15	Severe 16+

Dx:	**FOR OFFICE USE ONLY**		
◊ Sleep Apnea (Observed)	◊ Snoring (Habitual)	◊ Stroke	◊ Obesity
◊ OSA (Diagnosed)	◊ Gasping/Choking	◊ Heart Attack	◊ Insomnia
◊ Excessive Daytime Sleepiness	◊ Soft Tissue Abnormality (Upper Airway)	◊ Hypertension	◊ Depression

Rx:	**Other Services:**
◊ Two-night Home Sleep Study or __ -night	◊ Overnight attended Polysomnogram ◊ Sleep Specialist Consultation
◊ Diagnostic ◊ Efficacy (w/ oral appliance)	◊ CPAP/BIPAP Titration ◊ Other

NOTES:

Practice/Group Name ______ Doctor Name ______

Physical Address ______ Account Code ______

Phone ______ Fax ______ Email ______

State License ______ NPI # ______

Dr. Signature ______ Date ______ Office Contact ______

Anthony J. Tisoncik, DDS

PATIENT REFERRAL PROGRAM

We want to help you and your friends receive the best possible dental care available. There are so many exciting new materials and techniques to restore teeth that most people don't know exist. We value good people, as we are sure you do, too. We still have space available for new patients in our office, and we would like to offer to anyone you know who would value quality dentistry the opportunity to receive a special free dental consultation for new patient care.

For every patient that you refer to this office for dental care, we will credit your account with $25.00. Consider this a thank-you courtesy to be used towards any dental service that we provide! All that we ask is that you refer an individual outside of your immediate family who values quality dental care and personal attention. The greatest compliment you can pay us is by referring someone close to you.

Anthony J. Tisoncik, DDS

Anthony J. Tisoncik, DDS

9700 South Roberts Road • Palos Hills, IL 60465 • (708) 599-2929
www.PalosHillsDental.com

Anthony J. Tisoncik, DDS

FINANCIAL MENU

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you, regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options and welcome your suggestions and questions.

A) Split Payment

Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

B) Pre-Authorized Credit Card Agreement

With your permission and signature, we will charge your Visa, MasterCard, American Express, or Discover with an agreed payment amount each month. This allows you to make monthly payments without applying for additional credit.

C) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

D) Prepayment in Full (For treatment over $2000)

A prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

E) Chase Health Advance Plan

With fast approval over the phone from Chase Health Advance, your payment can be much lower than those available through our office. Chase Health Advance specializes exclusively in helping patients with larger dental cases to receive the treatment they want. Chase Health Advance carries fixed rates and can extend terms out to 60 months. There is no prepayment penalty. We will assist you in contacting them from our office.

F) Gradual Treatment Plan

FOR THOSE PATIENTS ON A LIMITED BUDGET. By prioritizing treatment, those patients who do not have dental insurance or are on a tight budget can still complete their dental work by spreading appointments over several months or years.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks, or Chase Health Advance Plan (see above).

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

I certify that I have read, fully understand, and accept the above financial policy.

Signature:____ Date:________________________________

Anthony J. Tisoncik, DDS

SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS

At Anthony J. Tisoncik, DDS, 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.

Anthony J. Tisoncik, DDS

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. If you are in need of an extended option, please just ask one of the patient services staff for an application.

9700 South Roberts Road • Palos Hills, IL 60465 • (708) 599-2929
www.PalosHillsDental.com

Anthony J. Tisoncik, DDS

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE 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:
Anthony J. Tisoncik, DDS
9700 South Roberts Road
Palos Hills, IL 60465
(708) 599-2929
www.PalosHillsDental.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