Richard M. Berg, DDS, FAGD
54 Copperfield Circle
Lititz, PA 17543
(717) 627-3113

Date: _____ Patient's Name: _____
Last First Middle

Address:_____
Street City State Zip Code

Soc. Sec. # _____- ___- _____ Birthdate ____/___/____ Home Ph. # ( ) _____ Cell Ph. # ( ) _____

Email: _____ Sex: M F If patient is a minor, parent's/guardian's name_____

Name of nearest relative not living with you: _____ Relationship: _____

Complete Address _____ Ph. # ( ) _____

Emergency Contact _____ Ph. # ( ) _____

Responsible Party Information

Name_____
Last First Middle Marital Status

Soc. Sec.# ____ - ___ - _____ Birthdate _____/_____/_____ Relationship to Patient _____

Mailing Address _____ How long at this address? _____
Street City State Zip Code

Home Ph. # ( ) _____ Work Ph. # ( ) _____ Email Address: _____

Previous Address (if less than 3 years) _____

Employer_____ Occupation _____ No. Years Employed_____

Employer Address_____

Spouse's Name ___ _____ Birthdate ____/___/____ Phone # ( ) _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. #_____

Place of Employment_____ Ph. # ( ) _____

Insurance Company _____ Group # _____

I.D. #_____

Insurance Co. Address _____ Ph. # ( ) _____

Consent

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. I also authorize doctor to perform all recommended treatment mutually agreed upon and to use the appropriate medication and/or therapy indicated for such treatment.
2. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due at the time services are rendered unless prior arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a $4.00 monthly late charge may be added to my account in addition to any collection charges.
3. I understand that credit bureau reports may be obtained and authorize this office to obtain same, at their discretion.
4. I understand that it is my responsibility to advise this office of any changes in the information obtained on this form.
5. I understand that the information on this form will be held in strict confidence.
6. I authorize the release of personal/dental information to any referral Dr. and/or insurance company. This includes (but is not limited to) treatment plans, radiographs, periodontal information, ADA codes and charges.

_____ _____ _____
Signature of Patient or Responsible Party Print Patient Name Date

Richard M. Berg, DDS, PC
54 Copperfield Circle
Lititz, PA 17543

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can gain 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. This Notice takes effect on August 1, 2013, and will remain in effect until updated.

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, referral office, hospital or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to health care service plans, insurance companies, self-insurers or their representatives 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. Genetic information will not be submitted for consideration in underwriting.

Your Authorization: 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 only 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 with authorization.

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 personal health information for marketing communications or sales 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 and 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 a rate of $20.00 for copies and 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 explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. You have the right to receive security breach notifications. 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 Information
Address: Richard M Berg, DDS, PC, 54 Copperfield Circle, Lititz, PA 17543
Telephone: (717) 627-3113 Fax: (717) 627-0723 E-mail: drberg@drberg.net

Richard M. Berg DDS, PC
Authorization &Acknowledgement of Consent

Clinical

- I authorize Richard M. Berg, DDS, PC referred to as "practice" hereafter, to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis.
- I authorize this practice to perform all recommended and agreed upon treatment. I also authorize the use of anesthetics, sedatives and other medication as necessary and am fully aware that using anesthetic agents involves certain risks.

Financial

- I understand that I am responsible for payment arrangements on date of services rendered on my behalf and my dependents. I am aware that a $4.00 monthly fee is automatically tabulated into my account if my balance is 90 days old or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.
- A $25.00 broken appointment fee may be charged to my account for all broken and/or last minute cancellations. I am aware that to keep operating costs down, 24 hour notice of cancellation is required.

Insurance

- I authorize this practice to release to staff, referral offices, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all records, photos, radiographs and information about my medical history, services rendered and outstanding treatment.
- I authorize this practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to this practice the insurance benefits providing assignment is to the practice. I understand that I am responsible for payment regardless of the coverage provided.

Health Insurance Portability and Accountability Act 1996:
HIPAA: Acknowledgement of Receipt of Notice of Privacy Practices & Consent for Use and Disclosure of Health Information
You may refuse to sign this Acknowledgement. You have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of your revocation. This revocation will not affect previous consent. We reserve the right to refuse to provide further treatment in your behalf or that of your dependents if this Consent is revoked or refused.

You have the right to read this practice's Notice of Privacy Practice before you decide to sign this Consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information. If privacy practice changes are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our current Notice of Privacy Practices by calling: (717) 627-3113, or mailing 54 Copperfield Circle, Lititz, PA 17543.

I have had the opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize Richard M. Berg, DDS, PC, to use and disclose my protected health information to carry out treatment payment activities and health care treatment. Signatures below indicate that I have read this entire document and understand the contents of this Acknowledgement.

_____	_____	_____
Print Patient Name	Signature	Date

Circle One: Patient/Parent/Guardian or Representative

Please list the individuals and their phone numbers to whom the practice may disclose your protected health information:

1.

2.

3.

Please note your preferred means of communication:

__ You may contact me at home and/or leave messages
__ You may NOT contact me at home or leave messages
__ You may contact me via my cell phone_____
__ You may contact me at work_____
__ You may NOT contact me at work
__ You may email me (unencrypted) messages
E-Mail Address_____