

TODAY'S DATE _____

PATIENT REGISTRATIONPATIENT NAME _____ AGE _____
LAST FIRST MIDDLEADDRESS _____
STREET CITY STATE ZIP

E-MAIL ADDRESS _____

PHONE: HOME _____
BUSINESS _____ EMPLOYER _____

BIRTH DATE _____

SOCIAL SECURITY NUMBER _____ SEX _____

SINGLE _____ MARRIED _____ WIDOWED _____ MINOR _____

PERSONAL PHYSICIAN: NAME _____
ADDRESS _____

NEAREST FRIEND OR RELATIVE IN CASE OF EMERGENCY:

NAME _____
ADDRESS _____
PHONE _____ RELATIONSHIP _____

METHOD OF PAYMENT:

CASH _____ CHECK _____ CREDIT CARD _____

INSURANCE CO. _____

PLAN NAME _____ ID # _____

SUBSCRIBER _____ DOB: _____

PERSON RESPONSIBLE FOR ACCOUNT _____

DISCOUNT PLANS CANNOT BE USED IN COMBINATION WITH ANY INSURANCE PLANS.
TWO DISCOUNT PLANS CANNOT BE USED TOGETHER.

HOW DID YOU HEAR ABOUT OUR OFFICE?

FRIEND _____ RELATIVE _____ NEWSPAPER _____ NETWORK _____

WE, AT DR. WOLKEN'S OFFICE, WILL MAKE OUR BEST EFFORT AT FILING YOUR INSURANCE, BUT ULTIMATELY YOUR BILL IS YOUR RESPONSIBILITY. THIS INCLUDES ALL SERVICES THAT ARE DENIED BY YOUR INSURANCE COMPANY.

I HEREBY UNDERSTAND THAT ALL SERVICES ARE CASH UNLESS SPECIFIC ARRANGEMENTS ARE MADE IN ADVANCE.

1-1/2% SERVICE CHARGE ADDED IF PAYMENT IS NOT RECEIVED ON DAY OF TREATMENT. AN 18% ANNUAL INTEREST RATE IS WHAT THIS EQUALS.

THIS FORM PROVIDES INFORMED CONSENT TO PROVIDE THE NECESSARY TREATMENT.

SIGNATURE

CONSENT TO PERFORM DENTISTRY

Richard J. Wolken, D.D.S., P.C.

1. I hereby authorize and direct the dentist(s) of _____ and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
 - A. Preventive hygiene treatment, (prophylaxis) and the application of topical fluoride.
 - B. Application of plastic "sealants" to the grooves of the teeth.
 - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
 - D. Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
 - E. Removal (extraction) of one or more teeth.
 - F. Treatment of diseased or injured oral tissues (hard and/or soft).
 - G. Use of sedative drugs to control apprehension and/or disruptive behavior.
 - H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
 - I. Use of general anesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgement of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
7. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time: _____ AM / PM File No: _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

Signature: Patient or Parent or Guardian

Witness

HIPAA Notice of Privacy Practices

Dr. Richard J. Wolken, D.D.S., P.C.
 216 N. Main St. 159 Marion Blvd.
 Monticello, IA 52310 Marion, IA 52302
 (319) 465-4666 (319) 377-4225

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination of management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates; Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

Contact Officer:

Dr. Richard J. Wolken
 216 N. Main St. 159 Marion Blvd.
 Monticello, IA 52310 Marion, IA 52302
 (319) 465-4666 (319) 377-4225

This notice was published and becomes effective on/or before **January 1, 2012.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance officer in person or by phone at our main phone number.

Dr. Richard J. Wolken, D.D.S., P.C.

**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.

Print Name _____

Signature _____

Date _____