Welcome To Our Practice!

Leslie H. Sultan, DDS, PA • Eastside Surgical Services, Inc.

Date:_____

Patient: (Mr., Mrs., Dr.) First Name _____ M.I. ___ Last Name _____ Nickname _____
Sex: ❑ Male ❑ Female Date of Birth _____ Age _____ Social Security # _____
Street _____ City _____ State _____ Zip _____
Home Tel.# (____) _____ Business Tel.# (____) _____ Ext.____ Employer _____
Cellular Tel.# (____) _____ Email address: _____
Dentist _____ _____ Medical Doctor _____ _____ Referred By _____ _____
(First Name / Last Name; FIRST NAME / LAST NAME; FIRST NAME / LAST NAME)
Nearest relative not living with you _____ _____ Tel. # (____) _____
(First Name / Last Name)
Have you ever been a patient of our practice? ❑ Yes ❑ No Method of Personal Payment: ❑ Cash ❑ Check ❑ Credit Card

Who will be in charge of your account? ❑ **Self** ❑ **Spouse** ❑ **Father** ❑ **Mother** ❑ **Other** _____
(If self, skip to next paragraph)
Name _____ _____ Soc. Sec.#: _____ Home Tel. # (____) _____
(FIRST NAME / LAST NAME)
Street _____ City _____ State _____ Zip _____
Employer _____ Tel. # (____) _____

Spouse or other guarantor information (if different from above)
Name _____ _____ Soc. Sec.# _____ Home Tel. # (____) _____
(FIRST NAME / LAST NAME)
Street _____ City _____ State _____ Zip _____
Employer _____ Tel. # (____) _____

INSURANCE INFORMATION

Patient: Student: Full Time ❑ Part Time ❑ Not ❑ School Name/Address _____ _____
(SCHOOL NAME / ADDRESS)
Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ❑ _____ _____ _____
(CITY / STATE / ZIP)
Employed: Full Time ❑ Part Time ❑ Retired ❑ Not ❑ Do you belong to a PPO or HMO? Yes ❑ No ❑

DENTAL INSURANCE

Insured _____ _____ **Relation** _____
(FIRST NAME / LAST NAME)
Sex: ❑ **M** ❑ **F** Date of Birth ____ ____ ____
Address _____
City _____ State____ Zip_____
Phone (____) _____ S.S.# _____

Insurance Co. _____
❑ **HMO** ❑ **PPO** ❑ **POS** ❑ **Traditional**
I.D.# _____ Group # _____
Phone (____) _____

Employer _____

MEDICAL INSURANCE

Insured _____ _____ **Relation** _____
(FIRST NAME / LAST NAME)
Sex: ❑ **M** ❑ **F** Date of Birth ____ ____ ____
Address _____
City _____ State____ Zip_____
Phone (____) _____ S.S.# _____

Insurance Co. _____
❑ **HMO** ❑ **PPO** ❑ **POS** ❑ **Traditional**
I.D.# _____ Group # _____
Phone (____) _____

Employer _____

IS THIS VISIT RELATED TO AN ACCIDENT? Auto: ❑ Yes ❑ No Work Related: ❑ Yes ❑ No Other: ❑ Yes ❑ No
Date of Injury _____ Insurance Co. handling this claim _____ Claim # _____
Adjustor _____ Tel # (____) _____ Fax # (____) _____
Attorney _____ Tel # (____) _____ Fax # (____) _____
Has a letter of protection been filed? ❑ Yes Date _____ ❑ No

FEES AND PAYMENTS

Please note that all fees due for services rendered are payable in full at the time of service. Certain insurances may cover a fixed amount (PPO, HMO) while others will cover a percentage of the charge. You will be given a estimate of your financial responsibility. You are required to pay any co-payments, deductible amounts or balances not covered by your insurance. A separate charge may be added and billed for the use of our JCAHO facility, Eastside Surgical Services, Inc. Anesthesia services by providers other than Dr. Sultan will be charged separately. Any unpaid balances over 90 days may be referred to a collections service, and therefore subject to collection costs, court costs and attorney's fees, unless other arrangements have been made. Your credit rating may become affected by an overdue balance. The signature below is your authorization for release of information necessary to process your claim. Payment is authorized to Leslie H. Sultan, DDS, PA D/B/A Broward OMS and/or Eastside Surgical Services, Inc. for benefits otherwise payable to me.

X _____ **X** _____

Patient (Parent or Guardian if minor) Date

Health History

To our patients: Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit:

		Yes	No
100.	Are you in good health? Height Weight		
101.	Have there been any changes in your general health in the past year?	❑	❑
102.	Are you under the care of a physician? Date of last visit	❑	❑
	If so, for what are you being treated?		
103.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
104.	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so describe where	❑	❑
105.	**Do you have a prosthetic joint/implant? If so, describe where**	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
106	Rheumatic fever?			
107	Damaged heart valves / mitral valve prolapse?			
108	Heart murmur?			
109	High blood pressure?			
110	Low blood pressure?			
111	Chest pain, angina?			
112	Heart attack(s)?			
113	Irregular heart beat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Bronchitis, chronic cough?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Tuberculosis?			
120	Emphysema?			
121	Difficult breathing / other lung trouble?			
122	Do you smoke?			
123	Blood transfusion?			
124	Blood disorder such as anemia?			
125	Bruise easily?			
126	Bleeding tendency (abnormal bleed)?			
127	Jaundice, hepatitis or liver disease?			
128	Infectious mononucleosis?			
129	Gallbladder trouble?			
130	Fainting spells?			
131	Convulsions, epilepsy?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
132	Stroke?			
133	Thyroid trouble?			
134	Diabetes?			
135	Low blood sugar?			
136	Kidney trouble?			
137	Are you on dialysis?			
138	Swollen ankles, arthritis or joint disease?			
139	Stomach ulcers?			
140	Contagious diseases?			
141	Sexually transmitted diseases?			
142	Problems with the immune system?			
143	Delay in healing?			
144	A tumor or growth?			
145	Radiation / chemotherapy for cancer?			
146	Chronic fatigue / night sweats?			
147	Are you on a diet?			
148	A history of drug abuse?			
149	A history of alcohol abuse?			
150	Contact lenses?			
151	Eye disease / glaucoma?			
152	Mental health problems?			
153	A removable dental appliance?			
154	Pain & clicking of jaws when eating?			
155	Malignant hyperthermia?			
156	**OSTEOPOROSIS OR METABOLIC BONE DISEASE:**			
	A. Have you taken medications for this condition? ❑ yes ❑ no			

MEDICATION

ARE YOU NOW TAKING....	Yes	No	Notes
201. Vitamins, Herbs, Supplements?			
202. Cortisone?			
203. Diet Pills?			
204. Tranquilizers?			
205. Aspirin?			

ARE YOU NOW TAKING....	Yes	No	Notes
206. Blood Thinners (Coumadin, Aspirin, Advil)?			
207. Have you ever taken the following: Fosamax, Boniva, Actonel, Zometa, Aridia			
208. Please list any other medications you are taking:			

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes
209. Local anesthetics?			
210. Penicillin?			
211. Other antibiotics?			
212. Sodium pentothal, valium, or other tranquilizers?			
213. Aspirin?			

ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes
214. Codeine or other narcotics?			
215. Other medications?			
216. Latex?			
217. Please list any allergies other than drug allergies:			

WOMEN

	Yes	No	Notes
218. Is there a possibility of pregnancy?			
219. Estimated delivery date? _____			

	Yes	No	Notes
220. Are you nursing?			
221. Are you taking birth control pills?			

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

OTHER

	Yes	No	Notes
222. Do you have problems with snoring or sleep apnea?			
223. Do you have problems sleeping?			
224. Do you feel that you are under stress?			
225. Do you grind your teeth, TMJ or Jaw Joint?			
226. Have you ever been diagnosed with a disorder of the the TMJ?			
227. Is there anything about your facial appearance that concerns you?			

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes ❑ No ❑

Do you wish to speak to the doctor privately about anything? ***Yes ❑*** ***No ❑***

Is there a **family history** of: 301. **Cancer** Yes ❑ No ❑ 302. **Diabetes** Yes ❑ No ❑ 303. **Heart Disease** Yes ❑ No ❑ 304. **Anesthetic Problems** Yes ❑ No ❑

IN CASE OF EMERGENCY, CONTACT: Name: _____ Tel # H: (____) _____ Wk: (____) _____

I understand the importance of a truthful health history to assist Dr. Sultan in providing the best care possible. I certify that I have read and understand the questions above, and have completed this form to the best of my knowledge. I will not hold Dr. Sultan and his staff responsible for any errors or omissions that I have made in the completion of this form. I am allowing Dr. Sultan to perform an oral and maxillofacial exam for the purpose of diagnosing and treating my condition. I understand that my health history needs to be updated at least every six months and I will inform this office of any changes in my health status and / or medication at each visit.

X
Date

X
Patient Signature (parent or guardian if minor)

Witness X

Doctor X

Patient: _____

Date: _____

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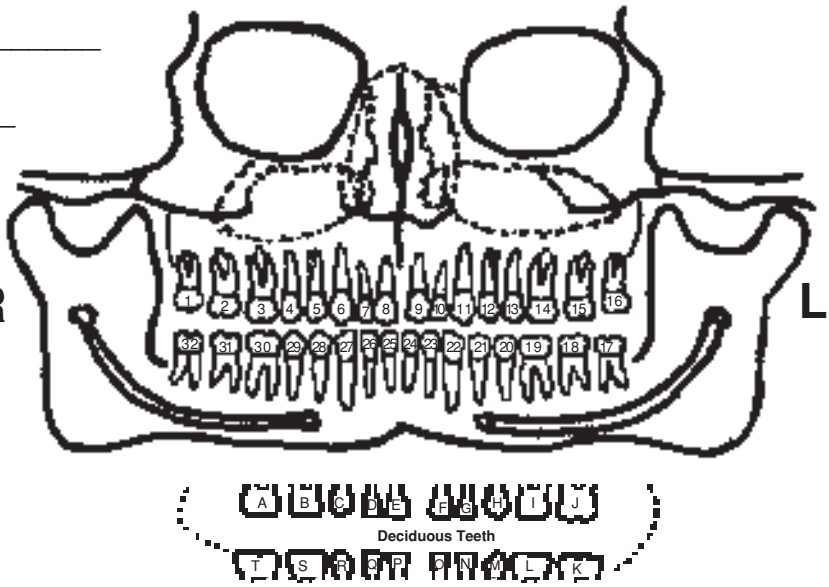

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DATE/DR.	TREATMENT AND PROGRESS NOTES			
	SUBJECTIVE	OBJECTIVE	ASSESSMENT	PLAN

Welcome to our office!

*W*e are happy to provide the following information about our practice in the hopes of making your initial experience informative and educational. Please review the enclosed material and do not hesitate to ask us about any questions you may have, or ***visit us online at www.sultansurgicalcenter.com***, the most comprehensive site devoted to the specialty!

Sultan Center for Oral Facial Surgery is the oral and maxillofacial surgery practice of Dr. Leslie H. Sultan. Dr. Sultan is the sole owner and operator of this facility.

*D*r. Sultan is Board Certified by the American Board of Oral and Maxillofacial Surgery and the National Board of Dental Anesthesia.

*I*n the course of your treatment, anesthesia services may be provided by either a Board Certified Anesthesiologist (MD) or a Board Certified Registered Nurse Anesthetist (CRNA) (under the direct supervision of Dr. Sultan). All anesthesia providers are employees of ANESCO. Please feel free to request a more detailed copy of their credentials. These licensed providers charge and bill separately for their services.

*O*ur practice works in coordination with other outside contractors to provide you, the patient, with comprehensive healthcare. Dr. Sultan does not have any contractual or financial ties with these contractors. These services include diagnostic radiology, or laboratory/pathology testing. As these services are provided outside our facility, these contractors will bill you separately and directly.

*O*ur practice is very concerned with your rights and responsibilities as a patient. Please review the enclosed Patient's Bill of Rights. Please note we do not accept advanced directives in our facility. If requested, we can convey this information to other potential healthcare providers.

*I*n order to assure your confidentiality within our practice, we adhere strictly to the guidelines of the Healthcare Information Portability & Accountability Act (HIPPA). Please review the enclosed HIPPA statement and sign the acknowledgement receipt.

*A*s part of our financial policy, all fees are due in full at the time of service. We accept all major credit cards, and offer many financing options. We are also providers for many HMO and PPO plans, and Medicare. Medicare has limited coverage for oral & maxillofacial surgery. Please inquire with our financial coordinator when registering for your visit, and be sure to bring with you all insurance information. A separate charge for facility services from Eastside Surgical Services, Inc. may occur for the use of our facility. Please note that when insurance does not cover the entire portion of your fee, you may be responsible for the remainder. One option prior to treatment is to obtain a predetermination of insurance benefits. If your insurance denies coverage or payment for services, we will discuss with you alternatives to treatment. A second opinion with another surgeon may be recommended. One alternative to treatment may be no treatment at all. Please be assured that we are available to discuss and resolve any billing or payment issues in a fair and equitable manner. Your account will be reviewed and all explanations to your inquiries will be provided.

I acknowledge that I have read and understand the above information.

Patient _____ Date _____

Assignment of Benefits Form

Financial Responsibility
I have read, understand, and agree to **Leslie H. Sultan, D.D.S., P.A.'s** Financial Policy. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient and are due 1 week prior to services being rendered, unless other arrangements have been made in advance by either me or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance and any other health / medical plan, to issue payment check(s) directly to **Leslie H. Sultan, D.D.S., P.A.** for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize **Leslie H. Sultan, D.D.S., P.A.** to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; 2.) To process insurance claims generated in the course of examination or treatment; and 3.) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Leslie H. Sultan, D.D.S., P.A.** on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I further understand that fees are due and payable 1 week prior to services being rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature Date

Date

Relationship to Patient

Witness Date

Date

Patient Receiving Services & Procedures
As a courtesy to me **Leslie H. Sultan, D.D.S., P.A.** has obtained information regarding specific benefits covered and payable under my health insurance plan from a representative of my health insurance company and has explained those benefits to me. I understand that **Leslie H. Sultan, D.D.S., P.A.** has acted in good faith in this effort and that the benefit information provided to **Leslie H. Sultan, D.D.S., P.A.** by my health insurance company may not be accurate.

I acknowledge that the benefit information obtained by **Leslie H. Sultan, D.D.S., P.A.** on by behalf was qualified by a representative of my health insurance company with the following statements: 1.) This is an estimate of the benefits provided under the patient's insurance contract; 2.) Any payment is subject to the coordination of benefits with any other insurance that may cover the services rendered and the coverage being in effect on the date of service; 3.) Verification of eligibility or benefits is not a guarantee of coverage or payment and is subject to any policy provisions and exclusions that are in effect at the time services are rendered.

Patient/Responsible Party Signature

Date

Cone Beam Computerized Tomography (CBCT)

The New Standard in Oral & Maxillofacial Surgery

We have chosen to be the first in Broward County to incorporate this new technology and all its exciting software applications into our practice. Compared to conventional panoramic x-rays, the use of Cone Bean CT technology can:

- **Provide for more accurate 3 dimensional diagnosis**
- **Promote reduced treatment time**
- **Lead to less invasive surgery**
- **Minor increases in radiation exposure**
- **Much less radiation exposure compared to conventional medical CT scanners**

Our practice now uses this digital technology exclusively in place of conventional x-rays.

If your visit is medically related, medical insurance may pay for your scan. Please provide all insurance information to our receptionist.

At this time, few dental insurance carriers provide coverage for Cone Beam CT technology.

The cost for a panoramic CT scan is $175. This will allow visualization sufficient for most dental procedures.

The cost for a facial cone CT scan is $325. This view is required for evaluation of the TMJ, traumatic injuries sleep disorders and jaw surgery.

Thank you very much. Please feel free to ask any questions about the use of CBCT technology in your treatment!

I have read and understood the above information.

Patient Name **Date**

Leslie H. Sultan, DMD, P.A.
5400 N. Federal Highway, Suite 102
Fort Lauderdale, FL 33308

Effective Date of this notice: April 14, 2003

NOTICE OF PRIVACY FOR DENTAL PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personal. The practice described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health status, and the services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and obligations regarding the use and disclose of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFROMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care. Such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

We work in open treatment areas. We will attempt to keep your personal health information (PHI) to the minimum.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third part. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior to approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and other patients receive quality care, for example. We may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or cleaning at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Products and Services

We may tell you about health related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communication about treatment alternatives or health related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive communications, we will not use of disclose your information for these purposes.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to so by federal, state or local law.

Research

We may uses and disclose health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illnesses.

Public Health Risks

We may disclose health information about your for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process subject to all applicable legal requirements.

Coroners Medical Examiner and Funeral Director

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceases person to determine the cause of death.

Information Not Personally Identifiable

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only your health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up; for example, filled prescriptions, medical supplies, or X rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already make with your permission.

If we have HIV or substance abuse information about you, we cannot release that information with a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our privacy official in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is

required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our privacy official. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) In not part of the health information we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the documents we made of medical information about you for the purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our privacy official. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction of limitation on the health information we use of disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care of the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide your emergency treatment.

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form information to our privacy official.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at certain location. For example, you can ask that we only contact you at work or by email.

To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications Form Information to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our privacy official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we have already about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our privacy official. You will not be penalized for filing a complaint.

BROWARD OMS
LESLIE SULTAN, D.M.D., P.A.

5400 N. Federal Highway, Suite 102, Fort Lauderdale, FL 33308

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ , have reviewed/received a copy of
Patient Name

BROWARD OMS 's Notice of Privacy Practices.
Practice Name

_____ _____
Signature of Patient / Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: