Welcome to our dental family!

We appreciate the trust you have placed in us, and we will strive to provide the highest quality of dental care that you expect and deserve.

The focus of our practice is health-centered, preventative dentistry. We enjoy helping people actively participating in their own healthcare and in controlling the causes of dental disease. This starts with diagnosis and may include various treatments of prevention, restoration, and maintenance, designed specifically for your dental needs. We offer a full range of services including restoration of dental implants, and aesthetic restorative treatment designed for long-term beauty, comfort, function, and low maintenance.

We truly aspire to make a difference in the lives of our patients. We take great pride in our ability to provide you with optimal dental care designed for your unique needs and desires.

The first step toward complete oral health is a thorough examination and diagnosis. We want our patients to make informed choices by fully understanding their dental problems. The doctor will review your dental needs with you at your initial appointment or, if necessary, at a later consultation appointment.

We kindly ask that you plan on paying in full as services are rendered unless other arrangements have been made. We will file dental insurance on your behalf and make every effort to get the maximum benefit allowed by your plan's coverage.

We look forward to seeing you and being a part of your healthcare team!

Sincerely,

Dr. Scott Novak and The Novak Dentistry Team

PATIENT REGISTRATION

PATIENT INFO *(PLEASE PROVIDE US WITH A COPY OF YOUR PICTURE ID AND DENTAL INSURANCE CARD)* Date____________________

FIRST NAME____________________ LAST NAME____________________

PREFERRED NAME____________________ GENDER____________________

ADDRESS____

CITY/STATE/ZIP____

HOME PHONE______________CELL PHONE______________WORK______________

SSN______________BIRTH DATE______________MARITAL STATUS______________

EMAIL____________________ ☐ I WOULD LIKE TO RECEIVE CORRESPONDENCE BY EMAIL

☐ I WOULD LIKE TO RECEIVE CORRESPONDENCE BY TEXT MESSAGE

☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ MILITARY

EMPLOYER____________________OCCUPATION____________________

PATIENT IS: RESPONSIBLE PARTY OR POLICY HOLDER (Circle one or both)

Whom may we thank for inviting you to our practice?____________________

RESPONSIBLE PARTY

FIRST NAME____________________ LAST NAME____________________

ADDRESS____________________CITY/STATE/ZIP____________________

HOME PHONE______________CELL PHONE______________WORK______________

SSN______________BIRTH DATE______________MARITAL STATUS______________

PRIMARY INSURANCE INFORMATION

NAME OF INSURED____________________RELATIONSHIP TO INSURED____________________

INSURED SSN____________________INSURED DATE OF BIRTH____________________

INSURANCE COMPANY____________________EMPLOYER GROUP____________________

INSURANCE ADDRESS____________________CITY/STATE/ZIP____________________

INSURANCE PHONE____________________

SECONDARY INSURANCE INFORMATION

NAME OF INSURED____________________RELATIONSHIP TO INSURED____________________

INSURED SSN____________________INSURED DATE OF BIRTH____________________

INSURANCE COMPANY____________________EMPLOYER GROUP____________________

INSURANCE ADDRESS____________________CITY/STATE/ZIP____________________

INSURANCE PHONE____________________

Novak Dentistry
AT RIVERWALK

GENERAL CONSENT FOR DENTAL PROCEDURES

Patient Name:____Date of Birth:___________________________

REGARDING MY MEDICAL HISTORY:

__________(INITIALS) I certify that the answers to the health and dental questionnaires are accurate and correct to the best of my knowledge. I understand that a change in medical or dental conditions(s), or a change in medications(s) may affect my dental treatment. I agree to notify Dr. Novak or any associates or employees of any changes that may occur.

REGARDING GENERAL CONSENT TO DENTAL PROCEDURES:

__________(INITIALS) I do hereby authorize and request the performance of dental services by Dr. Novak, associates, or employees they may designate, and the use of any procedures Dr. Novak or staff may deem necessary or advisable to maintain my dental health, the dental health of any minor or another individual for which I am legally responsible for. I understand that treatment options will be explained to me so that I may make an informed decision regarding my dental care or the dental care of a minor or dependent.

REGARDING ANESTHESIA AND MEDICATION:

__________(INITIALS) I understand that anesthetics may be used for therapeutic, diagnostic, or treatment purposes. I authorize for myself, and any minor or other individual for which I have legal responsibility, the administration of any anesthetics, or analgesics, including without limitation, therapeutic and/or other pharmaceutical agents (including those related to restorative, palliative, therapeutic, or surgical treatment) that may be deemed appropriate by Dr. Novak, associates or employees. I understand that antibiotics, anesthetics, analgesics, and other medications may cause complications and reactions including without limitation allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I also understand that additional complications may include, but are not limited to pain, swelling, bruising, temporarily limited opening, hematoma, cardiac stimulations, reduction in the effectiveness of birth control, muscle soreness, temporary or permanent numbness, and local infections. I further understand that on occasion anesthesia may be prolonged and in very rare cases, permanent. I understand that I may also request that no anesthetic be used at the time of treatment for myself, or any minor or dependent that I am legally responsible for.

REGARDING DENTAL TREATMENT:

__________(INITIALS) I understand that any treatment plans presented, along with the fees outlined, could change depending on the extent of dental pathology and the time elapsed since the diagnostic examination. I understand that once the treatment has begun, complications may arise that may dictate additional procedures or treatments. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. With an explanation of additional treatment, I authorize Dr. Novak to make any and all changes and additions as necessary. I understand that I may ask questions about any changes in treatment so I may make an informed decision regarding my dental care or the care of a minor or dependent.

__________(INITIALS) I understand that a more extensive treatment plan that originally discussed, including but not limited to root canal therapy, crowns, and/or surgical therapy (extraction and implants) may be required due to additional conditions discovered during or after dental treatment.

CONSENT: *I have had the opportunity to have all my questions answered by Dr. Novak, associates, or employees thereof, and I verify that I understand English. My signature below signifies that I understand that the recommended treatment and anesthesia will be explained to me together with the known risks and complications associated with such treatment. I hereby give my consent for any dental procedures, anesthesia, and treatment thereof by Dr. Novak and associates or employees.*

Patient/Guardian Signature:____**Date:**____________________________________

Printed Patient/Guardian Name:____

Relationship to Patient:____

Novak Dentistry
AT RIVERWALK

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET 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. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/01/11) and will remain in effect until we replace it.

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 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 or other healthcare provider providing treatment to you.

Payment: we may use and disclose your health information 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.

Your Authorization: in addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us 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 disclose your health information to a family member, friend, or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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, your location, your general condition, or death. If you are present, then prior to the 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 health information for marketing communications without your written authorization.

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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 or 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 by lawful intelligence, counterintelligence, and other national security activities. We may disclose to the correctional institution or law enforcement official having lawful custody of protected health information of inmates or patients 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 at the end of the 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 the Notice. If you request copies, we will charge you $2.00 for each page, $50.00 per hour for 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 an 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. 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 location and provide 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 website or by email, 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 Officer: HIPAA Compliance Officer
Telephone: 720-638-8093
E-mail: info@novakdentistry.com
Address: 115 Wilcox St, Suite 123 Castle Rock, CO 80104

Novak Dentistry
AT RIVERWALK

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 and allow the office to share information about my treatment with the following individuals (please give specific names, i.e. family members, other dentists, physicians, insurance companies, attorneys, etc.):

____
____ ____
____ ____
____

____
Print Patient Name

____
Date

____
Signature of Patient or Responsible Party

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify)

HIPAA AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION FOR EDUCATIONAL PURPOSES

I, ____, authorize Novak Dentistry to use photos, x-rays, and/or other dental information for educational purposes.

By initialing below, I authorize the use and/or disclosure of the following information:
________Still photos or video footage for use in educational lectures, educational discussions, and/or, publications. I understand that Dr. Novak will let me know prior to using my images.

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my healthcare will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorize the disclosure of the protected health information as stated.

____ Date:____
(Signature of patient/guardian.patient representative)

Printed Name:____ Relationship to patient:____
Declined:____

Novak Dentistry
AT RIVERWALK

PAYMENT OPTIONS

We want the handling of your account to be an extension of the professional care we provide you and your family. In order to eliminate surprises and help meet your needs, we are dedicated to offering customized financial plants. Communication is important, and therefore, one of our team members will review with you your treatment, its costs, and payment options prior to reserving an appointment time. This will allow you the ability to select the treatment to be scheduled, as well as your preferred method of payment.
Full payment is due at the time of service.
We accept cash, check, Visa, MasterCard, Discover, and American Express.

INSURANCE

As a courtesy to you, we will file all necessary documents with your insurance company the first business day after your appointment if you have provided us with sufficient information about your policy. As part of the financial arrangement process, our office will estimate your insurance coverage for a procedure, however, it is not possible for our office to be 100% accurate in the prediction of what your policy will cover. It is your responsibility as the patient to familiarize yourself with your specific policy. We are an independent provider and we do not guarantee any benefits you will receive from your insurance company. Ultimately, the cost of treatment is your responsibility.

COMMITMENT

Our office is dedicated to providing exceptional overall care. We appreciate your cooperation.

I have read the Financial Alliance. I understand, accept and agree with the Financial Alliance.

____ ______________________

Patient Signature or Responsible Party Date

Novak Dentistry
AT RIVERWALK

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient Name:____ Date:____________________________

Date of Birth:____

Practice/Provider
Name:____

Phone: ____

Address: ____

Please send records to: _________ Novak Dentistry
_________ Other:____

Information Requested:
___X___ Copy of Complete Dental Chart
___X___ Copy of Dental X-rays
______ Other (e.g. models – described)____

Purpose(s) for which information is to be used:
______ Transfer of records _____ Other ____

Authorization: *I certify that this request has been made voluntarily and that the information given above is accurate and to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.*

____ ____________________________________

Patient Name (print) Date

____

Patient Signature