

Advanced LASER Dental Group
Michael T. Hodish, D.M.D.
454 Main Avenue
Norwalk, CT 06851
Tel 203 849 1776
Fax 203 849 0162
Email mike@smilenorwalk.com
Internet www.smilenorwalk.com

Thank you for downloading the time saving welcome kit.

The first several pages are all administratively required details, such as medical history, insurance information, federal privacy disclosure, and so on.

Following that are driving directions, and a map of the neighborhood.

Note that we are in the same building as Bruce's Flowers, but we have our own parking area and entrance in the rear of the building. Enter off of Valley View Road, not Main Avenue.

Please fill out all of the forms and fax them to us at 203 849 0162, or scan them and email to cheryl@smilenorwalk.com.

Please read the form carefully about requesting x-rays from your previous doctor. They need YOUR authorization to send them. This works most efficiently if YOU actually make the request, not us. You can fax them the form we have provided. For best speed, go and pick up the x-rays yourself... then you will be absolutely certain that we will have them on your first visit.

Thanks again for taking the time to do this in advance. We will have all of your information in the computer before you arrive this way, so we can start immediately.

If you have not already done so, I invite you to have a look at the rest of our website (smilenorwalk.com) and learn a little more about us. It is full of interesting information about some of the things that set our practice apart.

Welcome to Advanced Laser Dental Group

Yours truly,

A handwritten signature in blue ink that reads "Michael". The signature is fluid and cursive, with a large initial 'M'.

Michael Hodish, D.M.D.

PLEASE COMPLETE THIS FORM AND SEND TO YOUR PREVIOUS DENTIST

ADVANCED DENTAL GROUP
Michael T. Hodish, D.M.D
454 Main Avenue
Norwalk, CT 06851
203-849-1776
Fax-203-849-0162

AUTHORIZATION TO RELEASE INFORMATION:

I, (patient name, printed) _____,
request that my dental records to be sent to the office of
Dr. Michael Hodish.

If digital, rather than sending hard copies, kindly email them to
reports@smilenorwalk.com.

Thank you,

Signature: _____

Date: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street _____ Apartment # _____

City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

FAX COMPLETED FORM TO 203-849-0162

Advanced Dental Group, P.C.

454 Main Avenue
Norwalk, CT 06851
☎ 203.849.1776 / 24 hours.

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This Federally required form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices.

ACKNOWLEDGEMENT (NOT PERMISSION) OF RESENTATION OF NOTICE OF PRIVACY PRACTICES

By Federal law: You May Refuse to Sign This Acknowledgement

Print name below

I, _____, have received and reviewed a copy of this
office's Notice of Privacy Practices

{Signature}

{Date}

For Office Use Only

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

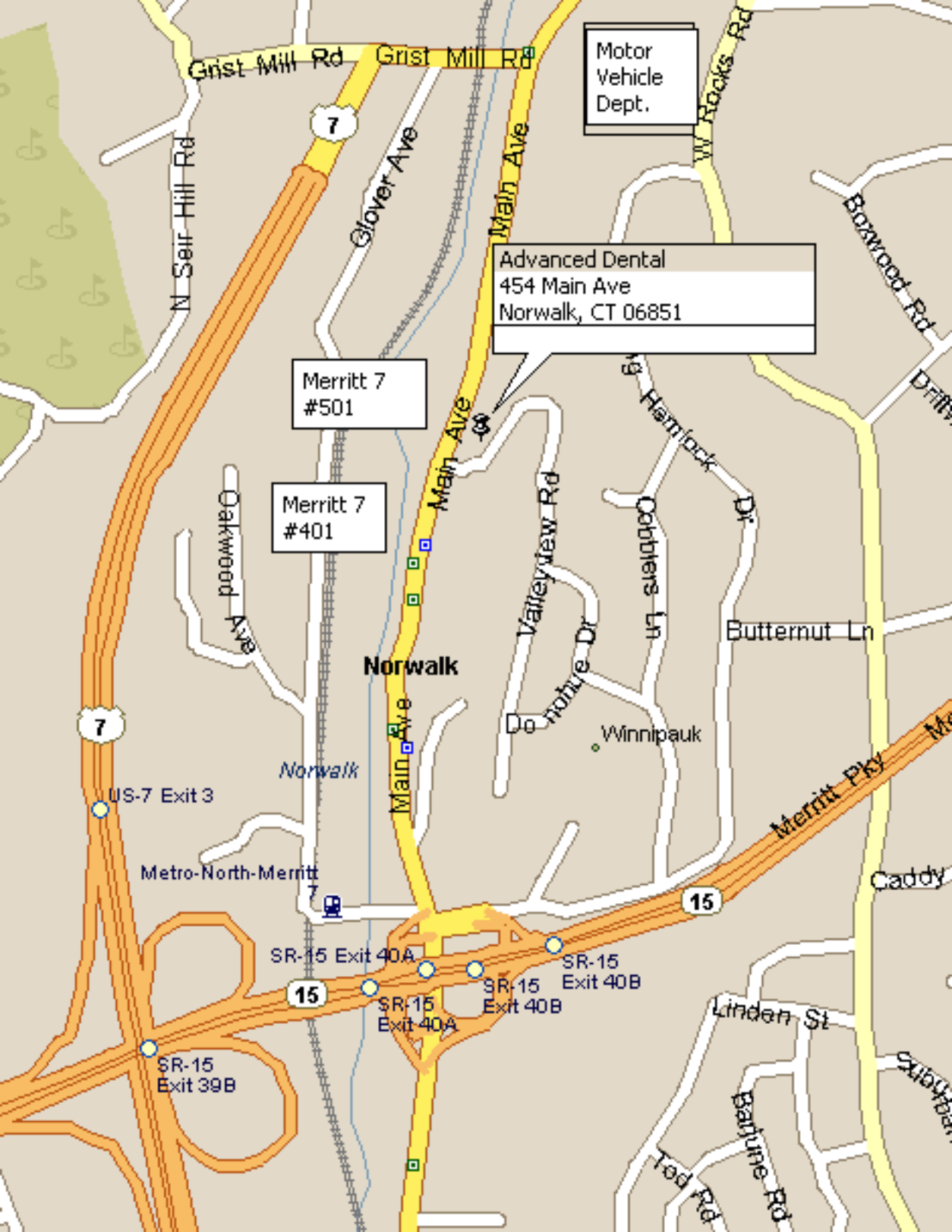
- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Driving directions to Advanced Dental Group:

From I-95: Take exit 15 onto the route 7 connector. Go to end of connector. Turn right at light. Go down hill, to end of road, turn right at light onto Main Avenue (Motor Vehicle Department will be right across the street).

Turn left at SECOND light onto Valley view Road. Make first left into our driveway. Park anywhere. Our entrance is the second to the last door at the far end of the building.

From Merritt Parkway: Exit 40 B, Main Avenue NORTHBOUND. Turn right. At THIRD light, turn right onto Valley view Road. Make first left into our driveway. Park anywhere. Our entrance is the second to the last door at the far end of the building.



Grist Mill Rd

Grist Mill Rd

Motor Vehicle Dept.

Advanced Dental
454 Main Ave
Norwalk, CT 06851

Merritt 7 #501

Merritt 7 #401

Norwalk

Winnipauk

Metro-North-Meritt

Merritt Pkwy

Linden St

Partridge Rd

Ted Rd

Sullivan

Caddy

Butternut Ln

Hamlock Dr

Cobbiers Ln

Valleyview Rd

Donohue Dr

Oakwood Ave

N Seir Hill Rd

VV Rocks Rd

Bowwood Rd

Drift

7

7

15

15

US-7 Exit 3

SR-15 Exit 40A

SR-15 Exit 40A

SR-15 Exit 40B

SR-15 Exit 40B

SR-15 Exit 39B

Norwalk



Advanced Dental Group, P.C.

454 Main Avenue
Norwalk, CT 06851

☎ 203.849.1776 / 24 hours.

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Advanced Dental Group, P.C.

454 Main Avenue
Norwalk, CT 06851

☎ 203.849.1776 / 24 hours.

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 (04/15/03), 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 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 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 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 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, 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, 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 health information for marketing communications 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 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 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 \$.50 for each page, 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, but not before April 14, 2003. 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 Officer: Cheryl Rivera, or Dr. Michael Hodish at Advanced Dental Group

Telephone: (203) 849-1776 Fax: (203) 849-0162 E-mail: hipaa@smilenorwalk.com

Mail: Advanced Dental Group / Hipaa 454 Main Avenue Norwalk, CT 06851