ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this Office's notice of Privacy Practices.

Print Name_____

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:

O INDIVIDUAL REFUSED TO SIGN

O COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

O AN EMERGENCY SITUATION PREVENTED IS FROM OBTAINING ACKNOWLEDGEMENT

O OTHER (PLEASE SPECIFY)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS 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 YOU HEALTH INFORMATION. WE MUST FOLLOW THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THIS NOTICE WHILE IT IS IN EFFECT. THIS NOTICE TAKES EFFECT APRIL 14, 2003, AND WILL REMAIN IN EFFECT UNTIL WE REPLACE IT.

WE RESERVE THE RIGHTS 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 RIGHTS TO MAKE SUCH CHANGES IN OUR PRIVACY PRACTICES AND THE NEW TERMS OF OUR NOTICE EFFECT FOR ALL HEALTH INFORMATION THE 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 A NEW NOTICE AVAILABLE TO YOU UPON REQUEST.

YOU MAY REQUEST A COPY OF OUR NOTICE AT ANY TIME. FOR INFORMATION ABOUT OUR PRIVACY PRACTICES, OR FOR ADDITIONAL COPIES OF THIS NOTICE, PLEASE CONTACT US USING THE INFORMATION LISTED IN 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 PHYSCIAN OR OTHER HEALTHCARE PROVIDING TREATMENT TO YOU.
PAYMENT: WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION TO OBTAIN PAYMENT FOR SERVICES WE PROVIDE FOR YOU.
HEALTHCARE OPERATIONS: WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN CONNECTION WITH OUR HEALTHCARE OPERATIONS HEALTHCARE OPERATIONS INCLUDE QUALITY ASSESSMENT AND IMPROVE ACTIVITIES, REVIEWING THE COMPETENCE OR QUALIFICATIONS OF HEALTHCARE PROFFESSIONALS, 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 OF 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 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, 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 VITIM OF OTHER CRIMES. WE MAY DISCLOSE YOUR HEALTH INFORMATION TO THE EXTENT NECESSARY TO AVERT A SERIOUS THREAT TO YOUR HEALTH OR SAFTEY OF THE HEALTH OR SAFTEY OF OTHERS.

AN IMPORTANT ALERT FROM REDWOOD GROUP

INSURANCE PROGRAM FOR DENTIST

SINCE MORE AND MORE CASES ARE ARISING FROM THE USE OF LOCAL ANESTHETICS, WE STRONGLY SUGGEST THAT YOU USE A CONSENT FORM FOR **ALL** LOCAL ANESTHETIC INJECTIONS. THE **CONSENT FOR LOCAL ANESTHETIC INJECTIONS** FORM BELOW IS ALSO AVAILABLE ON OUR WEB SITE AT REDWOODSGROUP.COM IN THE DENTISTS PROGRAM SECTION UNDER RECORD KEEPING SYSTEM.

I, (print name)_____, HEREBY AUTHORIZE DENTIST HYSIENIST/OTHER _____NAJIBE H. DOW, D.M.D._____ TO PERFORM A LOCAL ANESTHETIC INJECTION (S).

I UNDERSTAND, AND IT HAS BEEN EXPLAINED TO ME, THAT THERE ARE SOME RISKS IN THE ADMINISTRATION OF LOCAL ANESTHETIC. MOST RISKS ARE RELATED TO THE POSITION OF THE NERVES
UNDER THE TISSUE AT THE SITE OF THE INJECTION WHICH CAN NOT BE DETERMINED PRIOR TO ADMINISTRATION OF THE ANESTHETIC AGENT. ALTHOUGH THE RISKS SELDOM OCCUR THEY MIGHT INCLUDE LOSS OF, OR DISTURBED SENSATION OF THE TONGUE AND LIP ON THE SIDE OF THE INJECTION. IF THIS OCCURS IT IS OFTEN TEMPORARY, AND NORMAL SENSATION USUALLY RETURNS IN SEVERAL DAYS. HOWEVER, IN VERY RARE CASES THE LOSS OF SENSATION MAY EXTEND FOR A LONGER PERIOD AND MAY BECOME PERMANENT. IN ADDITION, INJECTING A FOREIGN SUBSTANCE INTO THE BODY SUCH AS AN ANESTHETIC AGENT MAY RESULT IN AN ALLERGIC REACTION. ALLERGIC REACTIONS TO THESE AGENTS ARE RARE, BUT MAY TAKE PLACE.

I FURTHER UNDERSTAND THAT INDIVUAL REACTIONS TO TREATMENT CANNOT BE PREDICTED, AND THAT IF I EXPERIENCE ANY UNANTICIPATED REACTIONS FOLLOWING THE INJECTION(S), I AGREE TO REPORT THEM TO THE OFFICE AS SOON AS POSSIBLE.

I HAVE BEEN TOLD THAT THE SUCCESS OF MY DENTAL TREATMENT DEPENDS UPON MY COOPERATION IN KEEPING SCHEDULED APPOINTMENTS, FOLLOWING HOME CARE INSTRUCTIONS, INCLUDING ORAL HYGIENE AND DIETARY INSTRUCTIONS, TAKING PRESCRIBED MEDICATION AND REPORTING TO THE OFFICE ANY CHANGE IN MY HEALTH STATUS.

I ACKNOWLEDGE THAT NO GUARANTEED OR ASSURANCES HAVE BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED.

I HAVE DISCUSSED ALL OF THE ABOVE WITH THE DOCTOR, AND HAVE HAD ALL MY QUESTIONS ANSWERED.

_____ _____
PATIENTS SIGNATURE IF A MINOR, SIGNATURE OF PARENT OR GUARDIAN

_____ _____
WITNESS SIGNATURE DENTIST/HYGIENIST/OTHER STAFF MEMBER

DATE_____