NOTICE OF PRIVACY PRACTICES

G. Larry Leonakis, DDS, Inc.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information Please review it carefully.

If you have any questions about this Notice please contact: our Privacy Contact who is Dr. Larry Leonakis.

This Notice describes your rights as a patient to access and control your medical records also known as protected health information or PHI. This Notice also describes our privacy practices and legal duties concerning how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by both state and federal law. Our office and staff will follow the privacy practices that are described in this Notice while it is in effect. When new regulations are created, we will update this Notice. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

Upon your request, we will provide you with any revised Notice of Privacy Practices by either calling this office or asking for one at the time of your next appointment. You may request a copy of our Notice at any time.

Uses and Disclosures of Protected Health Information

Your protected health information may be used for treatment, payment and healthcare operations. The following are examples of the uses and disclosures:

Treatment: We will use and disclose your protected health information to a doctor or other healthcare entity providing treatment to you. For example; we may provide your protected health information to a doctor to whom you have been referred in order to diagnose or treat you.

Payment: We may use and disclose your protected health information, as needed, to obtain payment for your health care services. For example, we may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services rendered.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in connection with our healthcare operations. This may include quality assessment activities, employee review activities and training, certifications, accreditation, and licensing. For example; we may call you by name in the waiting room when your doctor is ready to see you and we may contact you to remind you of your appointment.

Aside from using and disclosing your protected health information for Treatment, Payment or Healthcare Operations, you may give us **Authorization** to use or disclose your health information to anyone for any purpose. At any time in writing, you may revoke your authorization. If you do not give us **Authorization**, we cannot use or disclose your protected health information for any other reason except for treatment, payment, and healthcare operations.

Family and Friends: If you agree, we may disclose your protected health information to a family member, friend or other person to the extent the Privacy Rule allows, defined in this Notice.

Other Persons Involved in Care: Unless you object, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Additionally, using our professional judgement, we may allow a person to pick up your filled prescription(s), medical supplies, x-rays, or other similar forms of health information. In case of an emergency, we may use or disclose your protected health information that is directly relevant to the person's involvement in your healthcare.

Marketing: Our office will not use your protected health information for marketing purposes without your prior written authorization except for a face-to-face encounter or a communication involving a promotional gift of nominal value.

The Law: Our office will use or disclose your protected health information if and when either state or federal law requires it. If requested, you will be notified of any such uses or disclosures.

Other Uses or Disclosures of Your Protected Health Information: If we reasonably believe that you are a victim of abuse, neglect, domestic violence, or other crimes, we may disclose your protected health information to the proper authorities. We may disclose your protected health information for **public health activities** and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may disclose your protected health information to comply with workers' compensation laws and other similar legally-established programs. We may disclose your protected health information to military authorities of the **Armed Forces** if applicable. We may also disclose your protected health information to authorized federal officials for conducting **national security**, and **intelligence activities**. We may also disclose protected health information if it is necessary for **law enforcement authorities** to identify or apprehend an individual, or in response to a subpoena, discovery request or other lawful process. We may also disclose your protected health information to **researchers** when an institutional review board has approved their research. We may also use or disclose your protected health information to provide you with **appointment reminders**.

Your Individual Rights

Access: By written request, you have the right to inspect or receive a copy of your protect health information in part or in full. We may charge you $______, for each page and $_____ per hour for staff time plus any postage fee if applicable. If you request an alternative format for copies, we will charge you a reasonable cost-based fee for providing your health information in that format. Please feel free to contact us using the information listed at the end of this notice for a full explanation of or fee structure.

Under federal law, 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. Depending on the circumstances, a decision to deny access may be reviewed.

Amendment: You have the right to request an amendment of your protected health information. This request must be in writing and must explain the reason for such an amendment. We may deny your request under certain circumstances.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information, other than for treatment, payment, and healthcare operations. You have the right to receive specific information regarding these disclosures for up to 6 years that occurred after April 14, 2003.

Restrictions: You have the right to request restrictions on certain uses or disclosures of your protected health information, however, we are not required to agree to a restriction that you may request. If we do agree to your request, we will abide by our agreement unless of an emergency.

Alternative Communication/Location: By written request, you have the right to receive confidential communications from us by alternative means or at an alternative location. We will not request an explanation from you as to the basis for the request, however, we may condition this accommodation by asking you for information as to how payment will be handled or specifications of an alternative address or other method of contact.

Electronic Notice: If you agree to receive this Notice electronically, you may also request a paper copy.

Complaints: If you believe your privacy rights have been violated, you may file a written complaint with either our office by using the contact information listed below, or with the U.S. Department of Health and Human Services. If you do choose to file a complaint, we will not retaliate in any way.

We support your right to the privacy of your health information. If you would like more information about our privacy practices or have questions or concerns, please feel free to contact us.

Contact/Privacy Officer: Dr Larry Leonakis
Telephone: 775-882-0635 Fax: 775-882-3420
Address: 371 South Roop Street, Carson City, NV 89701

G. Larry Leonakis, DDS, Inc.

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices:

____

Please Print Name

____

Signature

____

Date

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgement of Receipt of our Notice of Privacy Practices was attempted, however acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other

____

____

____

____

G. Larry Leonakis, D.D.S., Inc.
371 South Roop Street, Carson City, NV 89701
(775)882-0635

INFORMED CONSENT GENERAL DENTAL TREATMENT

I understand that the following are possible risks and consequences to common dental procedures.

REACTION TO ANESTHESIA: I understand that to keep me comfortable while my tooth is being treated or extracted or if periodontal care is being performed, I will most likely receive a local anesthetic. I understand that this procedure is extremely safe but is an invasive procedure and there are some risks involved. I understand that on rare occasions I may have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces my ability to control swallowing, which increases the chance of swallowing foreign objects during treatment. I understand that on rare occasions the injection may give an "electric shock" feeling on the tongue, lip, or teeth. I understand that this rarely has any lasting effect on the area. I understand that on rare occasions an injection may cause my heart to beat harder and faster than normal because of the very small dose of epinephrine in the solution and that this usually lasts for a short period of time. I understand that on rare occasions this numbness last for a long period of time and rarely lasts permanently.

STIFF OR SORE JAW JOINT: I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open my mouth wide for several days. I understand that treatment may leave the corners of my mouth red or cracked for several days.

DRUGS AND MEDICATIONS: I understand that should it be necessary to prescribe medications or drugs, that antibiotics, analgesics, or other medications may on rare occasions cause allergic reactions. I understand that these reactions may be redness and swelling of tissues, pain, itching, vomiting, diarrhea, or anaphylactic shock. I understand that on rare occasions hospitalization is necessary. I understand that if I am given sedatives that they may make me drowsy temporarily or may reduce my coordination. I understand that ED Drugs such as Viagra or Cialis should not be taken 48 hours before a dental procedure.

TREATMENT PLAN CHANGES: I understand that during treatment it may be necessary to change or add procedures because of conditions that may be found while working on the teeth or supporting tissues that were not discovered during the examination. I understand that a common change may be root canal therapy following a routine restorative procedure.

REMOVAL OF TEETH: I understand that alternatives to removing teeth will be explained to me. I understand that if alternatives exist they may be root canal treatment, crowns or other restorations, or periodontal therapy. I understand that removing a tooth may not always remove all the infection that may be present and it may be necessary to have additional treatment. I understand that some of the risks involved with having teeth removed may be pain, swelling, spread of infection, dry socket, fractured jaw, or indefinite loss of feeling in teeth, lips, tongue or surrounding tissues. I understand that I may need treatment by a specialist if complications arise during or after treatment. I understand that the cost of this treatment would be my responsibility.

FILLINGS: I understand that if I have had fillings placed that I must exercise care during the first twenty four hours to avoid breakage of the fillings. I understand that a more extensive filling than originally diagnosed may be required due to additional decay not visible on an x-ray. I understand that significant sensitivity may be a common after effect of a recent filling. I understand that a filling weakens the tooth and that a thin weak area of the tooth is susceptible to fracture which may require additional treatment.

CONSEQUENCES OF NOT PERFORMING TREATMENT: I understand that the proposed treatment will help to relieve my symptoms. I understand that if no treatment is performed that I would continue to experience symptoms. I understand that these symptoms may include pain, infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort of my jaw joint, and the premature loss of teeth. I understand that infection can threaten my health.

I understand that dentistry is not an exact science and that neither Dr. Larry Leonakis nor associates can guarantee results. I acknowledge that no guarantee or assurance has been made regarding dental treatment which I may request or authorize. I understand that by signing below I acknowledge that I have received adequate information about the risks of common dental treatment. I have had all of my questions answered. I understand this form.

I understand that the dental office will explain treatment and provide a treatment plan. I understand that the dental office will inform me of possible complications of treatment or anesthesia. I agree to give Dr. Larry Leonakis and associates my consent to perform the treatment and whatever procedures deemed necessary or advisable. I agree to the use of local anesthetic and analgesia depending on the judgement of Dr. Larry Leonakis and associates. I understand that the dental office is not available for after hours care and if I have a true emergency I will need to seek treatment at an urgent care facility.

_____ I understand these risks and consequences and give my consent for treatment.
_____ I understand these risks and consequences and refuse to give my consent for treatment.

Patient Signature	Patient Name	Date
Dentist Signature	Witness Signature	Date

PATIENT NAME ______ Date of Birth ______ Age ______

Physical Address ______ How long ______

Mailing Address ______ City ______ State ______ Zip ______

Email ______ Social Security Number ______

Home Phone ______ Cell Phone ______

Employer ______ Years ______ Occupation ______ Work Phone ______

Person to Contact in case of Emergency: Name ______ Phone ______

Whom may we thank for referring you to our office? ______

SPOUSE INFORMATION

Name ______ Date of Birth ______ Age ______

Address ______ City ______ State ______ Zip ______

Home / Cell Phone ______ Social Security Number ______

Employer ______ Years ______ Occupation ______ Work Phone ______

RESPONSIBLE PARTY INFORMATION Relationship to Patient ______

Name ______ Date of Birth ______ Age ______

Address ______ City ______ State ______ Zip ______

Home / Cell Phone ______ Social Security Number ______

Employer ______ Years ______ Occupation ______ Work Phone ______

INSURANCE INFORMATION Insured's name ______ Birthdate ______ SSN ______

Primary Dental Insurance Plan ______ Insurance Company ______

Secondary Dental Insurance Plan ______ Insurance Company ______

MEDICAL HISTORY

Do you have or have you ever had:	YES	NO
Anemia		
Diabetes		
Hepatitis		
High Blood Pressure		
Heart Condition		
Abnormal Bleeding		
Rheumatic Fever		
Are you HIV positive?		
Tuberculosis		
Have you had any other serious illnesses?		
Date of last Medical Exam		
Are you under the care of a physician?		
If so, for what reason?		

Are you allergic to:	YES	NO
Penicillin or other Antibiotics		
Anesthetic Type: ______		
Other drugs:		
Are you a smoker? How Much? ______		
What medications are you taking?		
Do you have an artificial limb, joint, heart valve, pacemaker, screws, pins, rods or any other metal in your body?		
If yes, please explain:		

Are you pregnant? Yes ______ No ______ Due ______

Family Physician: ______

WE WILL NOT TREAT PATIENTS WITH ANY ACTIVE COMMUNICABLE DISEASES

I understand that I am financially responsible for this account. I understand that it is customary to pay for professional services when rendered.

I understand that insurance is a contract between me and my insurance company. I understand that my insurance company is not obligated to the dental office. The dental office will bill my insurance as a courtesy to me. The dental office will provide me with an insurance estimate prior to treatment. I understand that I am responsible for all fees related to treatment.

Insurance Authorization Signature On File: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
I hereby authorize and direct payment of the dental benefits otherwise payable to me directly to G. Larry Leonakis, D.D.S., Inc.

CHIEF CONCERN: ______

DATE OF LAST DENTAL VISIT: ______ **DATE OF LAST DENTAL CLEANING:** ______

SIGNATURE ______ **DATE** ______

PERIODONTAL STATUS

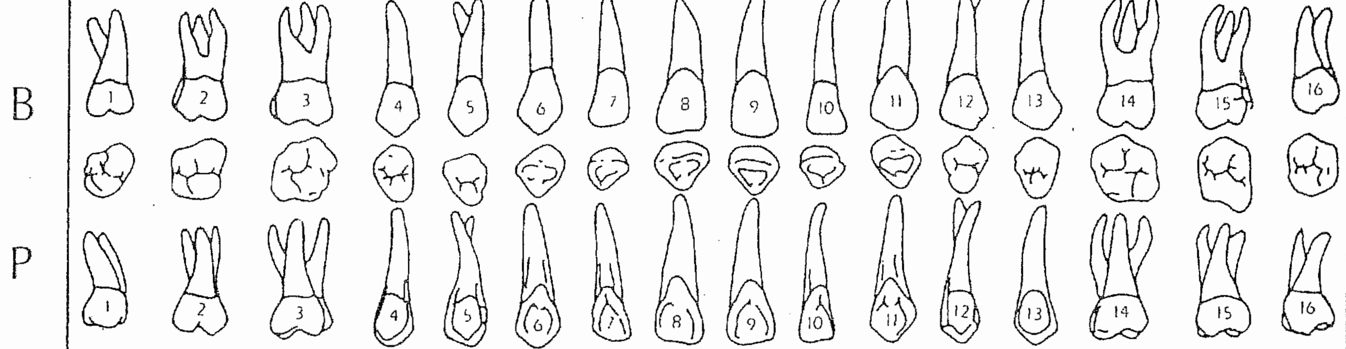
DATES:

Bleeding or Exudate Site:
Circle Box:

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
MOBILITY	C																	
	B																	
	A																	
RECESSION OR (+)	C																	
	B																	
	A																	
POCKETS	C																	
	B																	
	A																	

KERATINIZED GINGIVA MM (MARK ROOT)

B



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POCKETS	A																
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	C																
RECESSION OR (+) HYPERPLASIA	A																
	B																
	C																

		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
RECESSION OR (+) HYPERPLASIA	C																
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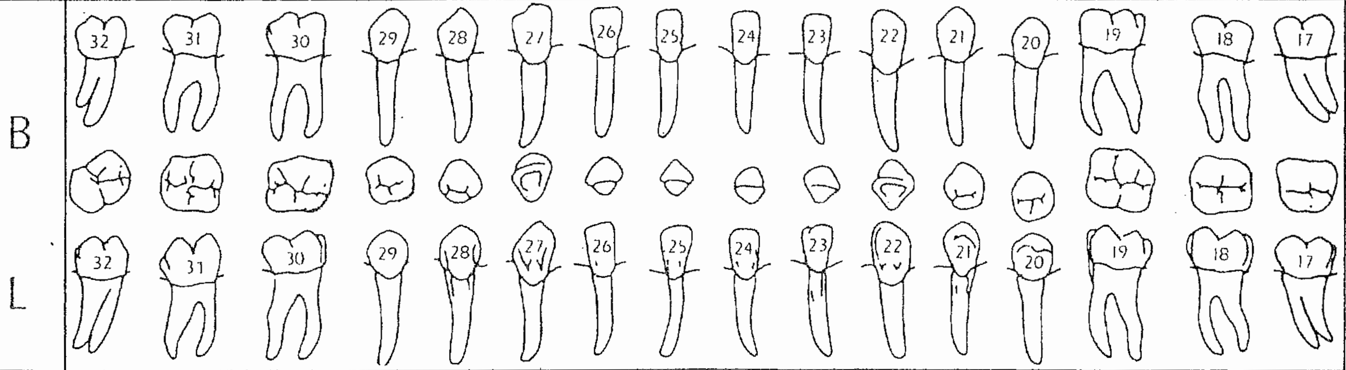
	A																
POCKETS	C																
	B																
	A																

KERATINIZED GINGIVA MM (MARK ROOT)

B



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		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
POCKETS	A																
	B																
	C																
RECESSION OR (+)	A																
	B																
	C																
MOBILITY	A																
	B																
	C																

Name ______ Address ______

Phone ______ City ______ State ______ Zip ______

Med. Alert ______ Dent. Alert ______

Form designed by Robert Ryan, D.D.S., P.C.

Form 9431 Colwell Systems Inc., Champaign, Illino

DATE	TOOTH NO.	SERVICES

DATE	TOOTH NO.	SERVICES