Dr. Raya Ben Dor
795 Starr Street
Phoenixville, PA 19460
(610) 933-8139

Welcome to our practice! This document contains the information required by law and many Health Plans to protect your rights, inform you of your rights and responsibilities. We are sorry that it is of such length, but we must comply with the terms and conditions that are imposed upon us so that we may serve you. By signing this form you are granting consent, authorizing and agreeing to the following terms and conditions:

Our Notice of Privacy Practices: I acknowledge receipt of Privacy Practices which provides more detailed information about how Starr Valley Dental may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this clause, and we encourage you to read it in full. You may obtain a copy of the current and revised notice by contacting our office. You may also take a written copy of the notice with you. You do not need to acknowledge receipt of our notice in order to receive care. Initials: ___________Date: ____/_____/______

All Other Insurance Companies and/or Third Party Payers: I HEREBY AUTHORIZE Starr Valley Dental and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Starr Valley Dental rendering the service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Guarantee of Payment: I UNDERSTAND that filing a claim with my insurance company or other third party payer, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Starr Valley Dental to me or the patient as indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. But is not limited to, claims filed for Workers' Compensation and/or other claims due to personal injury accidents/illnesses, which physicians, suppliers, and practitioners will bill and collect separately for their services. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment either because the plan deems such services not medically necessary or for any other reason.

Consent for Treatment: I hereby permit any treatment necessary to my dental care to include the administration or anesthetics, analgesics, sedatives, and nitrous oxide sedation, but only after these contemplated treatments and administrations have been fully and thoroughly explained to my satisfaction to include the possible adverse effects of both the procedures, anesthetics and drugs that may be employed.

Consent to Treat Minor: I, as the legal guardian and legal representative of the minor named below, authorize and request Starr Valley Dental, to provide medical care to the child or minor reasonable by today's standards at Starr Valley Dental.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

PATIENT SIGNATURE **DATE**

____ ________________

(if patient is 18 years or older, his/her signature is required in addition to the "responsible party")

RESONSIBLE PARTY (if other than the patient) **DATE**

____ _________________

Dr. Raya Ben Dor
795 Starr Street
Phoenixville, PA 19460
(610) 933-8139

WELCOME TO STARR VALLEY DENTAL!

PATIENT INFORMATION

Today's Date: ______________________________

Patient Name: ____ Patient's Date of Birth: ____________________

Patient's Address: ____________________________________ Patient's Social Security #: _________________

____ Patient's Phone #: ________________________

____ Cell Phone #: ____________________________

Patient's Age: ________________ Sex: __________________ Marital Status: ___________________________

RESPONSIBLE PARTY

Responsible Party: ___________________________________ Date of Birth: ____________________________

Address: ____ Social Security #: _________________________

____ Phone#: ________________________________

____ Cell Phone #: ____________________________

Relationship to Patient: _______________________________ Work Phone #: ____________________________

INSURANCE INFORMATION

Name of Insured: _____________________________________ Relationship to Patient: ____________________

Address: ____ Date of Birth: ____________________________

____ Social Security #: _________________________

Employer: ____ Phone: ________________________________

Address: ____ Union or Local #: _________________________

____ Group #: ________________________________

Insurance Company: __________________________________ Phone #: _______________________________

Address: ____ Member #:_______________________________

____ Family/Single Coverage: ___________________

ADDITIONAL INSURANCE

Name of Insured: _____________________________________ Relationship to Patient: ____________________

Employer: ____ Social Security #: _________________________

Insurance Company: __________________________________ Date of Birth: ____________________________

Dr. Raya Ben Dor
795 Starr Street
Phoenixville, PA 19460
(610) 933-8139

MEDICAL HISTORY FORM

Patient's Name:____________________

Primary Care Physician's name:______________________________

Primary Care Physician's address:____________________________

Primary Care Physician's phone:_____________________________

	Yes	No
Are you currently under medical care?	___	___
If so, what's the condition being treated?	___	___
Date of last physical exam ______________________		
Has there been any weight loss within the past year?	___	___
Have you ever had a serious illness or operation?	___	___
Have you ever had abnormal bleeding after an accident, surgery, or having a tooth pulled?	___	___
Have you ever required a blood transfusion?	___	___
Have you ever had surgery or x-ray (radiation) treatment for a tumor, growth, or other condition? ?	___	___
Do you have or have you ever had any of the following?		
Asthma?	___	___
Rheumatic fever or rheumatic heart disease ?	___	___
Heart abnormalities present since birth ?	___	___
Mitral valve prolapse ?	___	___
Heart murmur ?	___	___
Artificial joint prosthesis ?	___	___
Heart attack?	___	___
High blood pressure?	___	___
Stroke?	___	___
Pacemaker ?	___	___
Bypass surgery ?	___	___
Angina (chest pain) ?	___	___
Congestive heart failure ?	___	___
Anemia, sickle cell anemia, or other bleeding disorder?	___	___
AIDS/HIV ?	___	___
Cancer ?	___	___
If yes, what kind?____		
Diabetes?	___	___
Epilepsy, seizures, or fainting spells?	___	___
Glaucoma?	___	___
Hepatitis or liver disease ?	___	___
Kidney disease?	___	___
If yes, do you receive dialysis?	___	___
Lung disease?	___	___
Thyroid problems ?	___	___
Stomach ulcers ?	___	___
Tuberculosis ?	___	___
Venereal disease ?	___	___
Drug or alcohol abuse?	___	___
Any disease, condition, or problem not listed?	___	___

If yes, please explain:____
____

WOMEN:

Are you pregnant?	___	___
Are you presently breast feeding?	___	___

Are you allergic or have you ever reacted adversely to:

Local anesthetic	___	___
Penicillin or other antibiotics	___	___
If yes, which antibiotic___________________________________		
Aspirin	___	___
Codeine or other narcotics	___	___
Latex	___	___
Other: _________________________________		

Are you taking any of the following?	**Yes**	**No**
Medicine for high blood pressure	___	___
Antibiotics	___	___
Blood thinners (Coumadin, Warfarin, Plavix)	___	___
Aspirin or NSAID's (Motrin, Advil, etc.)	___	___
Steroids (cortisone, prednisone)	___	___
Dilantin or other anti-seizure medicine	___	___
Insulin or other drug(s) for diabetes	___	___
Digitalis or drugs for heart disease	___	___
Nitroglycerin	___	___
Narcotics (pain pills)	___	___
Birth control	___	___
Do you smoke?	___	___
Do you drink alcohol?	___	___

If yes, How often?_____________

PLEASE LIST ALL CURRENT MEDICATIONS

____
____
____
____
____

I certify that the information above is correct.

Patient's Signature   Date

______________________________   ________________

Dr. Raya Ben Dor
795 Starr Street
Phoenixville, PA 19460
(610) 933-8139

Starr Valley Dental

DENTAL HISTORY FORM

1. Are you having pain or discomfort at this time? (yes / no)
2. Do you feel very nervous about having dental treatment? (yes / no)
3. Have you ever had a bad experience in the dental office? (yes / no)
4. Are you satisfied with your smile and the appearance of your teeth and gum tissue? (yes / no)
5. What would you change about your teeth and smile if you could? ___________________________
6. Are you concerned about offensive breath odor? (yes / no)
7. What is your reason for seeking care at this time: _____________________________________
8. Do you have regular dental checkups? (yes / no)
9. When was your last dental exam: _______________________________
10. Do your gums bleed? (yes / no)
11. Have you had surgery performed on your gums? (yes / no)
12. Have you ever worn braces? (yes / no)
13. Do you grind your teeth? (yes / no)
14. Have you ever had any trauma to your face or mouth? (yes / no)
15. Do you floss? (yes / no) How often: ____________________________________
16. How many times a day do you brush your teeth? __________________________

How We Protect and Keep Your
Health Information Confidential

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 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

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 $0.25 for each page, $10.00 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, but not before January 1, 2011. 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.

Starr Valley Dental

Dr. Raya Ben Dor
795 Starr Street
Phoenixville, PA 19460
(610) 933-8139

Dr. Raya Ben Dor
795 Starr Street
Phoenixville, PA 19460
(610) 933-8139

FINANCIAL POLICY

INSURANCE: As a courtesy to all patients we will verify your dental insurance benefits. You are responsible to know your plan coverage, exclusions and limitations. Furthermore, you should be aware of non-covered benefits such as a missing tooth, crown/bridge/denture restorations, bruxism, downgraded limitations for filling and porcelain on crowns on molar teeth. Frequency limits for exams, prophylaxis, fluoride and x-rays etc.
The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, MasterCard, or Discover. To help you accept an extensive treatment plan, we are offering a Care Credit dental treatment Financing Program. All estimates are subject to final approval by your dental insurance plan. Therefore the amount due is subject to change after final explanation of benefits have been paid. (**initialize**) ______

INTIAL PAYMENT FOR DENTAL TREATMENT: Most plans are covered for routine clinical exam cleaning. No deductible is due for diagnostic or preventative treatment unless otherwise stated. There are some Plans with coinsurance payment for x-rays and dental exams. Deductibles for basic/major services customarily include fillings, crowns, extractions, root canal therapy and periodontal treatment.

FINANCIAL CHARGES: All returned checks are subject to $25 fee. All balances over 90 days are subject to interest in amount of 1.5% per month mandated by State law. We reserve the right to apply $20 rebilling fee and $25.00 late charges toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau. (initialize) ______

PAST DUE ACCOUNTS: In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all the fees including and not limited to attorney fees, court costs, and collection agency fees. (initialize) ______

MISSED APPOINTMENT FEE: Please note that there is a missed appointment fee of $50.00 per hour for all appointments canceled without at least 24 business hours' notice. Please give us a call in advance if you need to reschedule or cancel your appointment. (initialize) ______

This is an Agreement between Starr Valley Dental, as a provider of professional services and creditor, and the patient/debtor named on this form. By reading and signing this Agreement, you are agreeing and accepting this policy in full.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION: ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF STARR VALLEY DENTAL.

Print Name ____________________ (PATIENT/SUSCRIBER, if minor-Guardian)

SIGNATURE ______________________________ DATE ______________

Dr. Raya Ben Dor
795 Starr Street
Phoenixville, PA 19460
(610) 933-8139

RECORDS REQUEST AUTHORIZATION FORM

Records Request Authorization Form

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

____

Person or entity requesting the information and authorized to make the requested use or disclosure:____

Recipient of this information: ______________________________________

This information is being requested for the following purpose(s):

____

This authorization shall remain in effect form the date signed below.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (expect to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment)

Patient Name: ____________________ Signature: ___________ Date: ___________

Relationship to Patient (if signed by personal representative of Patient):_______________

Date:____________