

# Welcome Kit

**JOSEPH MANISCAICO DDS PC**  
P r o s t h o d o n t i s t  
family, aesthetic & implant dentistry

# New Patient Information

*Welcome to our practice.*

*Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.*

## Patient Information

Patient Number \_\_\_\_\_

Today's date \_\_\_\_\_  
First name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_  
I prefer to be called (nickname, etc.) \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Date of birth \_\_\_\_\_ Social security no. \_\_\_\_\_  
Home phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Primary contact number (please check one)  Home  Work  Cell Best time to call \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_ Driver's license no. \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Spouse's name \_\_\_\_\_ Spouse's employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

### If the patient is a child

School \_\_\_\_\_ School phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Grade \_\_\_\_\_

## Dental History

Reason for today's visit \_\_\_\_\_  
Are you currently in pain?  Yes  No  
If so, please describe: \_\_\_\_\_  
Do you have any dental problems now?  Yes  No  
If so, please describe: \_\_\_\_\_  
Have you ever had trouble with a previous dental treatment?  Yes  No  
If so, please describe: \_\_\_\_\_  
Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam \_\_\_\_\_ Date of last cleaning \_\_\_\_\_ Date of last full mouth X-rays \_\_\_\_\_  
Procedure(s) done at last dental visit \_\_\_\_\_  
Previous dentist's name \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Why are you changing dentists? \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_ How often do you brush your teeth? \_\_\_\_\_  
How often do you floss? \_\_\_\_\_ What type of bristles do you use?  Hard  Medium  Soft  
What other dental aids do you use? (Electric toothbrush, toothpick, etc.) \_\_\_\_\_

Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No

# New Patient Information

**Have you ever had:**

- |                                   |                              |                             |  |                              |                             |
|-----------------------------------|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Periodontal disease/gum treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Discomfort in your jaw joint (TMJ/TMD) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Orthodontics treatment            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Your teeth ground or bite adjusted     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Oral surgery                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Serious injury to the mouth or head    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A bite plate or mouth guard       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |                              |                             |

If yes to any of the previous questions, please describe \_\_\_\_\_

Is there anything else about your past dental treatment(s) that you would like us to know? \_\_\_\_\_

## Medical History

**Have you been hospitalized or under the care of a medical doctor during the past 2 years?**  Yes  No

If yes, for what? \_\_\_\_\_

Hospital or Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital or Physician's City \_\_\_\_\_ State \_\_\_\_\_

**Have you taken any medications or drugs in the past two years?**  Yes  No

**Are you currently taking any medications or drugs?** (including regular doses of aspirin or over-the-counter medicines)  Yes  No

If yes, please explain \_\_\_\_\_

**Have you ever taken Fen-Phen?**  Yes  No

If so, how long ago? \_\_\_\_\_

**Have you been to the doctor to check for heart problems?**  Yes  No

If so, what are the problems? \_\_\_\_\_

**Do you use tobacco?**  Yes  No **Do you use alcohol or any other controlled substance?**  Yes  No

**Women only:**

Are you pregnant or think you may be pregnant?  Yes  No Are you nursing?  Yes  No

Are you taking birth control pills?  Yes  No

**Indicate which of the following you have had or have at present:**

- |                           |                              |                             |                                  |                              |                             |                            |                              |                             |
|---------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|
| AIDS/HIV                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Difficulty Breathing             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lupus                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol/Drug Abuse        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies or Hives        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy or Seizures             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nervousness/Anxiety        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting or Dizzy Spells         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological Disorders     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis/Rheumatism      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frequent Headaches               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric/               |                              |                             |
| Artificial Heart Valve    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychological Care         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Bones/Joints   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hay Fever                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Therapy          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart (Surgery, Disease, Attack) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic/Scarlet Fever    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disease             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Pacemaker                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shingles/Chicken Pox       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Transfusion         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Disease/Traits | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bruise Easily             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia/Abnormal Bleeding     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Trouble              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer/Chemotherapy       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis A B C (circle)         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Snoring/Sleep Apnea        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High or Low Blood Pressure       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach Problems/ Ulcers   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold Sores/Herpes         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hospitalized for Any Reason      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Colitis                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Ankles             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Contact Lenses            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Trouble                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cortisone Medicine        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis (TB)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                                  |                              |                             | Tumors                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diet (Special/Restricted) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                                  |                              |                             | Venereal Disease/STD       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Please list any serious medical condition(s) that you have ever had not listed above:**

**Are you aware of having an allergic (or adverse) reaction to any of the following:**

- |                              |                              |                             |                                 |                              |                             |              |                              |                             |
|------------------------------|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|--------------|------------------------------|-----------------------------|
| Aspirin                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Iodine                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sedatives    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Codeine                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jewelry/Metals                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sulfa Drugs  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anesthetics (i.e. Novocaine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Latex                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tetracycline | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Erythromycin                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Penicillin or Other Antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____  |                              |                             |

**Patient signature** \_\_\_\_\_

# New Patient Information

## Dental Insurance

### Primary Carrier

Insurance co. name \_\_\_\_\_ Insurance co. phone \_\_\_\_\_  
Address (Street, City, State, ZIP) \_\_\_\_\_  
Group no. (Plan or Policy no.) \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_  
Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Date of birth \_\_\_\_\_ Insured's social security no. \_\_\_\_\_  
Insured's employer name \_\_\_\_\_ Is insured a patient in our practice?  Yes  No

### Secondary Carrier

Insurance co. name \_\_\_\_\_ Insurance co. phone \_\_\_\_\_  
Address (Street, City, State, ZIP) \_\_\_\_\_  
Group no. (Plan or Policy no.) \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_  
Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Date of birth \_\_\_\_\_ Insured's social security no. \_\_\_\_\_  
Insured's employer name \_\_\_\_\_ Is insured a patient in our practice?  Yes  No

### Person Financially Responsible for Account

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Social security no. \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Driver's license no. \_\_\_\_\_ Date of birth \_\_\_\_\_  
Address (Street, City, State, ZIP) \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Preferred payment method:  Cash  Credit Card  Check  
Visa/MC/AMEX no. \_\_\_\_\_ Exp. date \_\_\_\_\_  
If patient is a minor, name of parent or legal guardian and relationship \_\_\_\_\_  
Is this parent or legal guardian currently a patient in our office?  Yes  No

### Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

*I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.*

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Person to contact in case of emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Cell phone \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

### OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date \_\_\_\_\_ Initials \_\_\_\_\_

# Smile Analysis

Today's date \_\_\_\_\_

Patient Number \_\_\_\_\_

1. Do you love the way your smile looks?  Yes  No

2. Do you feel comfortable showing your teeth when you laugh or smile?  Yes  No

3. If you could change anything about your smile, it would be (check all that apply):

- Color of your teeth       Too much or too little of teeth show when you smile       Gaps between your teeth  
 Size/Shape of your teeth       Too much or too little of gum shows when you smile       Alignment of your teeth  
 Other: \_\_\_\_\_

4. Do you have (check all that apply):

- Sensitive or receding gums       Worn/broken/chipped teeth       Old or discolored fillings       Missing teeth  
 Old crowns that have dark edges at the top       Other: \_\_\_\_\_

5. In your line of work or lifestyle, do you (check all that apply):

- Visit businesses or clients       Travel       Speak publicly       Other: \_\_\_\_\_

6. If you had a smile makeover do you think you'd feel (check all that apply):

- More confident       More optimistic       Healthier  
 Just OK       No different       Other: \_\_\_\_\_

7. Do you or someone in your family have issues with any of the following (check all that apply):

- Chronic bad breath       Grinding teeth       Snoring  
 Other: \_\_\_\_\_

*We'd like to know more about you so we can better serve you!*

8. Do you prefer appointments in the (check all that apply):

- Early morning       Early afternoon       No preference  
 Late morning       Late afternoon       Other: \_\_\_\_\_

9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. What type(s) of music do you enjoy? (check all that apply)

- Easy Listening       Classical       Rock       Hip-Hop/Rap  
 Jazz       Country       R&B       Other: \_\_\_\_\_

11. What are your favorite hobbies or activities?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Do you have children and grandchildren? If so, please list their names and ages.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Is there anything else that you want our office to know about you that will help us to serve you better?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Health History Update

**Today's date** \_\_\_\_\_ **Patient Number** \_\_\_\_\_

First name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Anything else we should know?** \_\_\_\_\_

\_\_\_\_\_

**Health changes since last visit:** \_\_\_\_\_ **Date health change occurred** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's name \_\_\_\_\_ Physician's phone \_\_\_\_\_

Current medications

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Last physical exam \_\_\_\_\_ Any allergies? \_\_\_\_\_

Patient signature \_\_\_\_\_ Staff initials \_\_\_\_\_ Date \_\_\_\_\_

**Health changes since last visit:** \_\_\_\_\_ **Date health change occurred** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's name \_\_\_\_\_ Physician's phone \_\_\_\_\_

Current medications

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Last physical exam \_\_\_\_\_ Any allergies? \_\_\_\_\_

Patient signature \_\_\_\_\_ Staff initials \_\_\_\_\_ Date \_\_\_\_\_

## **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.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of Your Health Care Information**

#### **Treatment**

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. (example)

*"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with this practice."*

*"It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

#### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

*"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

#### **Workers' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

#### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

#### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings.**

We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement.**

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons.**

We may disclose your health information to coroners or medical examiners.

**Organ Donation.**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Research.**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

**Public Safety.**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

**Specialized Government Agencies.**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Marketing.**

We may contact you for marketing purposes or fund-raising purposes, as described below: (example)

*"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

*"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of practice sponsored fund-raising events."*

### **Change of Ownership.**

In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

### **Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

### **Changes to this Notice of Privacy Practices**

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Privacy Officer by calling this office.

**Complaints**

Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

This notice is effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

## Citi® Health Card: For Consumers



Simplify treatment financing  
with flexible payment plans.

## Features &amp; Benefits

## For Consumers

[Overview](#)[Features & Benefits](#)[FAQs](#)

Some things in life can be put off. Fortunately, quality health care doesn't have to be one of them. The Citi Health Card offers flexible payment plans at participating providers that allow you to get the treatments you need right now. Other benefits include:

**Flexible payment plans**

- Flexible Payment Plans on qualified purchases and revolving credit option at participating providers (see your provider for details)
- Low monthly payments and no pre-payment penalties
- No down payment required
- Separate account for health care expenses keeps other credit available for personal use

**Easy to use**

- [Apply Now](#) or at your provider's office and get a fast credit decision
- No need to reapply for additional treatments or purchases
- Account can be used for all family members
- Accepted at a variety of participating provider offices
- View, manage and pay your account online

**Easy to manage**

- Health care treatment purchases made at participating providers are billed to the Citi Health Card account, allowing easy separation of health care expenses and your everyday purchases
- View, manage and pay the Citi Health Card online