



**Liver** Y – N (Please circle conditions)

Hepatitis A      Hepatitis B      Hepatitis C      Jaundice or liver disease

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**Kidney** Y – N ( Please circle conditions)

Kidney transplant      Dialysis treatment      Frequent urination

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**Gastrointestinal** Y – N (Please circle conditions)

Ulcers    Diverticulitis      Bowel problem    Gastric bypass    Reflux/heartburn GERD    Eating disorder

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**Blood/Endocrine** Y – N (Please circle conditions)

AIDS/HIV+      Hemophilia      Sickle cell      Diabetes      Hypoglycemia      Anemia  
Thyroid      Sexually transmitted diseases

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**Allergies** Y – N (Please circle conditions)

Local anesthetic      Aspirin      Penicillin or other antibiotics      Codeine or other narcotics  
Iodine      Latex      Hives or skin rash      Sulfa drugs      Asthma or hay fever      Metal

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**Mental Health/Nervous** Y – N (Please circle conditions)

Depression      Sleep disorder      Epilepsy/Seizures      Fibromyalgia      Schizophrenia      Anxiety    Bipolar  
Autism      ADHA/ADD attention deficit

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**Other** Y – N (Please circle conditions)

Cancer      Radiation therapy      Chemotherapy      Cold sores      Severe headaches/Migraines  
Delayed healing      Chronic fatigue      Arthritis

**List of medications:**

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\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



8500 75th Street, Suite 104 • Kenosha, WI 53142 • 262-697-0077

Dr. Michelle DiStefano, D.M.D

**Financial Information:**

Insurance coverage is only an estimate. Guarantor is responsible for all treatment not covered by insurance. Fees for professional services rendered are payable in full on day of service unless a specific payment plan has been approved in advance of treatment. A service charge of 1% per month will be made on all account balance which are over 120 days old.

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**Signature**

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**Date**



## Notice of Privacy Practices

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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.

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### OUR LEGAL DUTY

This notice applies to health information about you that we create or receive and that identifies you. This notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information.

We are required by law to:

- Maintain the privacy of your health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our notice that is currently in effect;
- You may request a copy of our Notice at any time.

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### 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 dentist, 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 necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and healthcare professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

**Appointment Reminders:** We may disclose or use your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail or email.

**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 you 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 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.

**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.

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## 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 may charge you a \$20 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

**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. 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 a Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**We have the Right to Change our Privacy Practices and This Notice:** We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will provide a copy of it to you on request. The effective date of this policy is September 1<sup>st</sup>, 2013 and will remain in effect until we replace it.

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## 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.

Privacy Officer: Dr. Michelle DiStefano

Telephone: (262) 697 0077

Fax: (262) 697 6190

Address: 8500 75<sup>th</sup> St. Suite 104  
Pleasant Prairie WI, 53142



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

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Please Print Name

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Signature

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Date