NORTHWESTERN DENTAL IMPLANTS, LLC
APEX-NORTHWESTERN DENTAL GROUP, LLP

Corporate Office: 7745 N. Milwaukee Avenue, Niles IL 60714

HIPAA 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 notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to you past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing healthcare to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, you protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to,

quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may disclose you protected health information in the following situations without your authorization. These situations include: as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and drug administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors and Organ Donation: Research Clinical Activity: Military Activity and National Security: Workers' Compensation: Inmate: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to Inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compile in reasonable anticipation of, or use in, a civil, criminal, or administrative action or preceding, and protected health information that is subject to the law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family member or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your filling a complaint.**

This notice was published and becomes effective on/or before **April 14,2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with the respect to protected health information. If you have any objections to this form, please as to speak with our HIPAA
Compliance Officer in person or by phone at our Main Phone Number.

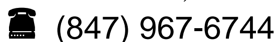
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____

Signature:____

Date:____

L. A. Mulvaney, DDS, MBA, President.
David Mortensen, DMD. Paulina Brzozowski-Sawicki, DDS.
Ankur N. Patel, DDS. Kevin T. Ladesic, DDS. Richard C. Kruger, DDS.



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www.northwesterndentalgroup.com
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Financial Consent Form

Our practice is committed to providing exceptional dental treatment at charges that are reasonable. Please understand it is the policy of this practice to request payment at the time services are rendered. As a courtesy to our patients we will file claims on your behalf, once you have provided us with the correct insurance information.

Not all insurance plans pay the same benefits or apply the same deductible, thus there may be a balance due after the insurance has paid that you would be billed for beyond what you have paid at the time of service. All balances are the responsibility of the patient regardless of insurance. Since the insurance contract is an agreement between you and your insurance company any unpaid portion remains the responsibility of the insured patient. I agree to pay my estimated portion of charges at the time of service and I further agree to pay Northwestern Dental Group within 30 days, any balance remaining on my account. Deposits made for certain appointments/procedures, may only be refunded in exceptional circumstances.

Accounts with no payment activity or those with previous arrangements not adhered to will be considered past due after 60 days and may be referred to an agency for delinquent accounts. We accept cash, check or credit card (American Express, Discover, MasterCard, and Visa) payment. Northwestern Dental Group is authorized to charge my credit card for any unpaid fees or charges relating to appointments made or procedures performed, or charges not covered by my insurance.

I have read and understand this financial commitment.

Thank you for choosing us as your Dental Health Care Provider.

Signature: ______________________________ Date: ______________________________

Print Name: ______________________________

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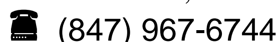
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Client missed appointment letter and agreement

Dear Valued Client;

Our team here at Northwestern Dental Group is truly here to try to make your oral care as easy, efficient and cost effective as possible.
We promise to do our very best to be here for you and to be on time. We would like to ask the same of you.

If you need to change or cancel your appointment at any time, please just call us, during business hours, and we will be more than happy to accommodate you.
Please, please, please; if you need to miss an appointment;
Give us enough time to give your reservation to another who may be waiting for an appointment.
48 hours notice is best.

This is how our system works best.
We will happily forgive the first time a client misses an appointment without notice. It happens! You will very nicely receive a warning about our deposit system.
The second time it happens we will sadly require a non refundable deposit in order to make future appointments, this amount will be applied to your visit, if kept, and the deposit will be lost if the appointment is missed without adequate notice.

Please sign below to let us know that you have read and understand this regrettable necessity.

Signed ____ Date _________________________

Surgical Appts

All Surgical appointments are booked with a deposit made with the Treatment Coordinator.
Surgical appointments **cancelled with in 48 hours will forfeit their deposit**.

Signed ____ Date __________________________

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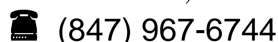

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Permission to leave messages / send post cards / text messages / emails

I ____ (Please Print Full Patient Name)

Give Northwestern Dental Group permission to leave voice messages regarding my dental appointments on my answering system or voicemail:

YES NO

Give Northwestern Dental Group permission to send me appointment reminder post cards via mail:

YES NO

I also give Northwestern Dental Group permission to send me appointment reminders via E-mail and text messages:

YES NO

Signed ____ Date __________________________

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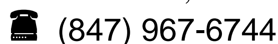
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