Joshua M. Ignatowicz, DMD
1070 W. Horizon Ridge Parkway Suite 120
Henderson, NV 89012
(702)473-5100

Dear Patient,

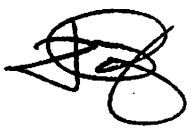
It is our goal to help you enjoy the benefits of good dental health for the rest of your life. Today's dentistry makes this goal possible for practically everyone. We have alwaysbeen known for our gentleness and don't expect to change.

We are also proud of our highly trained staff. Each one has been handpicked for his or her ability to serve you. We realize that you are an individual with preferences of your own, so we try to personalize our approach to each patient. Alternative methods andfees will be discussed openly, and you may choose what is best for you.

On your first visit with us, we will listen to your dental concerns and answer all of your questions thoroughly. You can expect a thorough examination with only necessary x-rays and a discussionof the most appropriate treatment to meet your oral health needs.

Please contact us if you have any questions, concerns, or if youwill be unable to keep this scheduled appointment. We look forward to meeting you!

Sincerely,



Joshua M. Ignatowicz, DMD
& Dental Team

WELCOME!

We are pleased to welcome you to our practice. Please take a few minutes to fill this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient's Name_____ Soc. Sec. #_____
Last First Initial

Patient's Birthdate:____/_____/_____ Sex: _____ Email:_____

Home Phone:_____ Cell Phone: _____

Address:_____ City: _____ State: ____ Zip:_____

Patient Employed By:_____ Business Phone:_____

Spouse's Name:_____ Soc. Sec. #:_____
Last First Initial

Spouse Employed By:_____ Business Phone:_____

In case of emergency, who should be notified?_____
Name Phone

Referred by (Who may we thank for referring you?)_____

Insurance

Person Responsible for Account_____
Last First Initial

Primary Dental Insurance Coverage:_____ Phone Number:_____

Member #:_____ Group #: _____

Secondary Dental Coverage:_____ Phone Number:_____

Member #: _____ Group #:_____

Preferred Pharmacy:_____ Phone Number:_____

Authorization

- I authorize the dentist to perform an examination, diagnostic procedures, and prophylaxis as may be necessary for proper dental evaluation.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment toanother dentist.
- I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature_____ Date_____

Payment is due in full at time of treatment

Minor

IF YOU ARE UNDER THE AGE OF EIGHTEEN YEARS

Name of Father:_____ SS#_____ Birthdate ____/____/____

Father Employed By:_____ Business Phone:_____

Name of Mother:_____ SS#_____ Birthdate ____/____/____

Mother Employed By:_____ Business Phone:_____

DENTAL HISTORY REPORT

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is confidential.

Patient Name_____ Date _____

1. Former Dentist:_____

2. When did you last visit a dentist?_____ Were X-rays Taken? _____

What treatment was done?_____

Why did you leave that practice?_____

3. Have you lost or have had any teeth removed, including wisdom teeth? Yes ☐ No ☐

Why?_____

4. Do you have any bridgework or dentures? Yes ☐ No ☐

5. Are you unhappy with the replacement? Yes ☐ No ☐ Why?_____

6. Do you feel your breath is offensive at times? Yes ☐ No ☐

7. Have you ever been told you have gum disease? Yes ☐ No ☐

8. Have you ever had gum treatment or Surgery? Yes ☐ No ☐

9. Does food chronically collect between your teeth? Yes ☐ No ☐

10. Are your teeth acutely sensitive to: Heat ☐ Cold ☐ Sweet ☐ Pressure ☐ None ☐

11. How often do you brush?_____ Floss?_____

12. Do you clench or grind your teeth? Yes ☐ No ☐

13. Does your jaw click or pop? Yes ☐ No ☐

14. Do you have frequent headaches? Yes ☐ No ☐

15. Have you had any orthodontic work? Yes ☐ No ☐

16. Has any dental treatment been recommended to you that has not been done?_____

_____

17. Anything else that would be valuable for us to know?_____

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature_____ **Date**_____

MEDICAL HISTORY

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is confidential.

Patient Name:_____ Date of Birth: ____/____/____

1. Name of Primary Care Physician:_____ Phone #:_____
2. When was your last physical examination?_____
3. Are you now under the care of a physician?_____ If so, for what reason? _____

_____

4. Have you been told you should be taking an antibiotic (premedication) prior to dental visits?..... Yes ☐ No ☐
5. Are you taking a blood thinner (Coumadin)?..... Yes ☐ No ☐
6. Are you presently taking any medications/drugs/pills?..... Yes ☐ No ☐
7. Are you currently pregnant (if so, how long)?..... Yes ☐ No ☐
8. Do you have any allergies to: Penicillin ☐ Codeine ☐ Latex ☐ Anesthetic ☐ Other ☐

9. Do you have, or have you ever had (circle):

Heart Trouble.....	Yes	No	Arthritis.....	Yes	No
Heart Murmur.....	Yes	No	Excessive/Prolonged bleeding.....	Yes	No
Heart Surgery.....	Yes	No	Fainting Spells.....	Yes	No
Heart Pacemaker.....	Yes	No	Jaundice.....	Yes	No
Rheumatic Fever.....	Yes	No	Hepatitis Type:____.....	Yes	No
High or Low Blood Pressure.....	Yes	No	Asthma or Hay Fever.....	Yes	No
Ulcers.....	Yes	No	Sinus Trouble.....	Yes	No
Tuberculosis/Lung Disease.....	Yes	No	Cancer (type)_____.....	Yes	No
Diabetes.....	Yes	No	Chemotherapy/Radiation.....	Yes	No
Epilepsy or Seizure Disorders.....	Yes	No	Stroke.....	Yes	No
Anemia.....	Yes	No	Glaucoma.....	Yes	No
Thyroid Problem.....	Yes	No	Psychiatric Care.....	Yes	No
Chemical Dependency.....	Yes	No	Venereal Disease.....	Yes	No
Smoke/Chew or Tobacco use.....	Yes	No	HIV Positive/AIDS/ARC.....	Yes	No
			Prosthetic Implant/Joint Replacement...	Yes	No

10. Have you ever had any other serious illnesses, hospitalizations, or accident? If so, explain_____

_____

11. Please list all the medications that you are currently taking._____

_____

Patient/Guardian Signature:,_____ Date:_____

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, Visa, Mastercard, American Express, and Care Credit.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient/Responsible Party:_____ Date:_____

Appointments and Cancellations

We take pride in our warm, caring atmosphere. One aspect we really enjoy about our practice is the opportunity to offer quality care and individual attention to each and every patient. We like having that personal time with you. When that time is lost due to an appointment cancellation, other patients in need of treatment cannot be seen and your treatment is delayed. For those reasons, we have the following office policy:

We will make every effort to remind patients by telephone, text, or e-mail prior to the appointment but please do not depend on this courtesy. If we are unable to contact you directly, your appointment card or appointment phone call will serve as confirmation of your appointment and it implies your obligation to be present. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $55 cancellation fee. If commitments for appointments are frequently broken, a non-refundable reservation fee equal to the appointment fee may be required.

Our ultimate goal is to help you achieve optimum dental health. Broken appointments only serve to delay your dental care and the opportunity to achieve that goal.

Thank you for your cooperation.

Patient Signature_____ **Date**_____

UPDATED NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. THE PRIVACY OF YOUR HEALTH IS IMPORTANT TO US. **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect.

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 provide the new Notice at our practice location and will distribute it 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.

Your Authorization : In addition to our use of your health information for the following purposes, 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 written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You or Your Personal Representative : We must disclose your health information to you, as describe in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with worker's compensation or similar programs.

National Security : We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 the protected information of an inmate or patient under certain circumstances.

Secretary of HHS: We will disclose your health information to the Secretary of the US Dept of Health & Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters.)

YOUR HEALTH INFORMATION 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 practically do so. You must make a request in writing to obtain access to your health information such as electronically. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If there is a cost to copying your personal health information we may charge you a reasonable, cost-based fee.

If you are denied a request, you have the right to have the denial reviewed in accordance with applicable law.

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 April 14, 2003. 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 the additional requests.

Restriction : You have the right to request that we place additional restrictions on our use or disclosure of your health information. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health concerns, or when disclosure is required by law.) We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must request this in writing.) Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the alternative, we will use what information we have.

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. If we agree to your request, we will amend your record and notify you of such. If we deny, we will provide you with a written explanation as to why it was denied.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured PHI as required by law.

Electronic Notice : You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by e-mail.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions, 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 you may notify us by using the contact information listed at the end of this Notice. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint 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 US Department of Health and Human Services.

CONTACT:	HIPAA COMPLIANCE COMMITTEE TELEPHONE: 507-583-2141
	Fax: 507-583-7574
E-MAIL:	oa@mainstreetdentalclinics.com
ADDRESS:	405 E. Main Street, Blooming Prairie, MN 55917

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I have received a copy of Dr. Ignatowicz's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgement

_____An Emergency situation prevented us from obtaining acknowledgement

_____Other (please specify)