LifeSmiles of New Hope, PC
Dr. Dharmesh Parbhoo
49 Hosiery Mill Road, Suite 125
Dallas, Georgia 30157

Welcome to our office. We will do our best to make your appointments as convenient and as pleasant as possible. We ask that you please complete **ALL** paperwork so that we may better serve you. If at anytime you have any questions, please feel free to ask any of our team members for help.

Patient Information (Confidential) **Today's Date: _____**

Patient Name : _____
Preferred Name : _____
Address : _____
_____
Primary Phone # : _____
Second Phone # : _____
Primary E-Mail : _____
Employer : _____
If College Student: Full Time □ Part Time □
School Name: _____
Relationship to patient: Self □ Parent □ Guardian □
Emergency Contact Name: _____
Emergency Contact Phone: _____

SSN : _____
Date of Birth : _____
Single : □ Married : □ Divorced : □
Minor : □ Widowed : □

Spouse's Name : _____
Spouse's D.O.B : _____
Spouse's SSN : _____
Spouse's Employer:_____
Spouse's Primary Phone # : _____

What is your preferred method of contact: Primary Phone □ E-Mail □
How did you hear of our office: _____
Whom may we thank for referring you : _____

I, the patient or guardian, certify that the above information is complete and accurate and I authorize any information to be released regarding medical or dental history, treatment, or credit reference to LifeSmiles of New Hope, P.C.. **I understand that if there is ANY change in the information provided above, it is my responsibility to notify the office in writing.**

_____ _____ _____ _____
Patient, Parent or Guardian name Signature Date Time

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Our insurance coordinators at LifeSmiles are happy to assist you in filing dental/medical claims as a **courtesy to you** so that you may maximize your health care benefits. Please be aware that your dental/medical benefits are a private contract between you, your employer and the insurance company only. LifeSmiles of New Hope, PC is **NOT** a party to that contract. **You are responsible for 100% of all fees not paid for by your insurance plans.** ***Please initial that you have read and understand this paragraph:*** _____

Insurance Authorization (Confidential)

Today's Date: _____

Primary Dental Insurance

Insurance Carrier _____ Employer _____
Subscriber's Name _____ Subscriber's Date Of Birth _____
Subscriber's ID # _____ Group # _____
Insurance Address _____ Insurance Phone # _____
_____

Secondary Dental Insurance

Insurance Carrier _____ Employer _____
Subscriber's Name _____ Subscriber's Date Of Birth _____
Subscriber's ID # _____ Group # _____
Insurance Address _____ Insurance Phone # _____
_____

Primary Medical Insurance

Insurance Carrier _____ Employer _____
Subscriber's Name _____ Subscriber's Date Of Birth _____
Subscriber's ID # _____ Group # _____
Insurance Address _____ Insurance Phone # _____
_____

I, the patient or guardian, authorize the release of any information, including diagnosis and records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. **I understand that if there is ANY change in the information provided above, it is my responsibility to notify the office in writing. I further understand that LifeSmiles insurance coordinators are NOT able to verify and coordinate your benefits on the same day as services are rendered.**

_____	_____	_____	_____
Patient, Parent or Guardian name	Signature	Date	Time

LifeSmiles of New Hope, PC
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The dental care you receive has an important interrelationship with the health problems that you may have, and medications you may be taking. It is required that you provide the following information to help us treat you as effectively and safely as possible. If you have questions, require additional forms or need help, please do not hesitate to ask a LifeSmiles team member. ***Please initial that you have read and understand this paragraph:_____***

Medical History and Present Illness (Confidential) **Today's Date: _____**

Patient Name _____ DOB _____ Height _____ Weight _____

Allergies—Hypersensitivities

□ Aspirin	□ Penicillin	□ Tetracycline
□ Sulfa	□ Erythromycin	□ Local Anesthetics
□ Codiene	□ Latex	□ Other _____
□ Nuts	□ Metal	□ No Known Allergies

List ALL drugs (Rx or OTC) currently being taken

Name of Medication	Dosage	How Taken

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_____ _____ _____ _____

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Medical History and Present Illness (Confidential) **Today's Date: _____**

Patient Name _____ **Date Of Birth _____**

Are you under a physician's care now?	Yes ☐ No ☐	If yes, name and phone of treating physician(s)
Have you ever been hospitalized or had a major operation in the past 5 years?	Yes ☐ No ☐	If yes, explain:
Have you ever had a serious head or neck injury?	Yes ☐ No ☐	If yes, explain:
Are you taking or have you taken Bisphosphonate for osteoporosis: such as Actonel, Boniva, Fosamax, Zometa or Aredia?	Yes ☐ No ☐	If yes, explain:
Do you smoke, use chewing tobacco, consume alcohol or other controlled substances?	Yes ☐ No ☐	If yes, explain:
Do you take **ANY** non-prescription medications, herbal supplements, aspirin, ibuprofen, multivitamins, Vitamin E?	Yes ☐ No ☐	If yes, explain:
Have you ever been advised to take Pre-medication for dental visits?	Yes ☐ No ☐	If yes, explain:
Women: Are you pregnant, trying to get pregnant, taking birth control or nursing?	Yes ☐ No ☐	If yes, explain:

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_____ _____ _____ _____

Patient, Parent or Guardian name Signature Date Time

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Medical History and Present Illness (Confidential) **Today's Date: _____**

Patient Name _____ **Date Of Birth _____**

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

AIDS / HIV	Yes ☐ No ☐		Cortisone Medicine	Yes ☐ No ☐
Allergies	Yes ☐ No ☐		Diabetes	Yes ☐ No ☐
Alzheimer's Disease	Yes ☐ No ☐		Drug Addiction	Yes ☐ No ☐
Anaphylaxis	Yes ☐ No ☐		Eating Disorder	Yes ☐ No ☐
Anemia	Yes ☐ No ☐		Emphysema	Yes ☐ No ☐
Angina / Chest pains	Yes ☐ No ☐		Epilepsy or seizures	Yes ☐ No ☐
Arthritis / Gout	Yes ☐ No ☐		Excessive Bleeding	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐		Excessive Thirst	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐		Fainting spells / dizziness	Yes ☐ No ☐
Asthma	Yes ☐ No ☐		Frequent or persistent Cough	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐		Frequent Diarrhea	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐		Frequent Headaches	Yes ☐ No ☐
Bruise Easily	Yes ☐ No ☐		Glaucoma	Yes ☐ No ☐
Cancer	Yes ☐ No ☐		Heart attack / Failure	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐		Heart Murmur	Yes ☐ No ☐
Celiac Disease	Yes ☐ No ☐		Heart Pace Maker	Yes ☐ No ☐
Congenital Heart Disorder	Yes ☐ No ☐		Heart Trouble / Disease	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐		Hemophilia	Yes ☐ No ☐

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_____ _____ _____ _____

Patient, Parent or Guardian name Signature Date Time

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Medical History and Present Illness (Confidential) **Today's Date: _____**

Patient Name _____ **Date Of Birth _____**

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Hepatitis A,B,C,D,OR E	Yes ☐ No ☐		Renal Dialysis	Yes ☐ No ☐
Implants—Hip/Breast/ Knee/Tooth	Yes ☐ No ☐		Rheumatic Fever	Yes ☐ No ☐
HPV	Yes ☐ No ☐		Rheumatism	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐		Scarlett Fever	Yes ☐ No ☐
Hives or Rash	Yes ☐ No ☐		Stomach/Intestinal disease/ Ulcers	Yes ☐ No ☐
Hypoglycemia	Yes ☐ No ☐		Shortness of Breath	Yes ☐ No ☐
Irregular Heartbeat	Yes ☐ No ☐		Sickle Cell Disease	Yes ☐ No ☐
Kidney Problems	Yes ☐ No ☐		Sinus Trouble	Yes ☐ No ☐
Leukemia	Yes ☐ No ☐		Special Diet	Yes ☐ No ☐
Liver Disease	Yes ☐ No ☐		Spina Bifida	Yes ☐ No ☐
Low Blood Pressure	Yes ☐ No ☐		Shingles/Herpes/Cold Sores	Yes ☐ No ☐
Lung Disease	Yes ☐ No ☐		Stroke	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐		Swelling of Limbs	Yes ☐ No ☐
Osteoporosis	Yes ☐ No ☐		Thyroid Condition	Yes ☐ No ☐
Periodontal disease	Yes ☐ No ☐		Tonsillitis	Yes ☐ No ☐
Psychiatric Care	Yes ☐ No ☐		Tuberculosis	Yes ☐ No ☐
Radiation Treatments	Yes ☐ No ☐		Tumors or Growths	Yes ☐ No ☐
Recent Weight Loss	Yes ☐ No ☐		Yellow Jaundice	Yes ☐ No ☐

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_____ _____ _____ _____

Patient, Parent or Guardian name | Signature | Date | Time

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Dental History and Present Illness (Confidential) **Today's Date: _____**
Patient Name _____ **Date of Birth: _____**

Name of your previous dentist/dental office	Phone #	City and state
May we contact your previous dentist?	Yes □ No □	Reason why you left your previous dentist?
Are you nervous when visiting the dentist?	Yes □ No □	If yes, explain:
List your 3 main dental concerns: 1._____ 2._____ 3._____	Have you researched your concerns? Yes □ No □	If yes, explain:
Do you have Pain, Dysfunction or a Quality of life (PDQ) issue with any part of your head and neck?	Yes □ No □	If yes, explain:
Have you ever had a sleep study or have you been diagnosed with sleep apnea?	Yes □ No □	If yes, when and who was the treating doctor?
Rank the following in importance to you when making decisions regarding your dental care. 1 is most important to you and 5 is least important to you. Rank each column separately.	Rank 1 to 5 __ Esthetics __ Function __ Comfort __ Long Lasting __ Short term fix	Rank 1 to 5 ____ What my insurance covers ____ What treatment is best for my health ____ Overall cost of treatment ____ Time it takes to complete treatment ____ Fear of dental treatment

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_____ _____ _____ _____
Patient, Parent or Guardian name Signature Date Time

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Dental History and Present Illness (Confidential) **Today's Date: _____**

Patient Name _____ **Date Of Birth:_____**

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Periodontal(Gum) Disease			**Dentures and Partials**	
History of deep cleaning	Yes ☐ No ☐		I need a denture or partial	Yes ☐ No ☐
History of gum surgery	Yes ☐ No ☐		I don't like my denture or partial	Yes ☐ No ☐
I have bad breath	Yes ☐ No ☐		I want something more permanent	Yes ☐ No ☐
My gums bleed / hurt	Yes ☐ No ☐		**Restorative / Implants**	
My gums are receding	Yes ☐ No ☐		I have missing teeth	Yes ☐ No ☐
My teeth are loose or shifting	Yes ☐ No ☐		I have cavities	Yes ☐ No ☐
Orthodontics (Braces)			I have chipped or broken teeth	Yes ☐ No ☐
I have crooked teeth	Yes ☐ No ☐		I have pain in my mouth	Yes ☐ No ☐
I have spaces between my teeth	Yes ☐ No ☐		I have sensitive teeth	Yes ☐ No ☐
I have an underbite	Yes ☐ No ☐		I don't like my smile	Yes ☐ No ☐
I have a crossbite	Yes ☐ No ☐		I don't like the color of my teeth	Yes ☐ No ☐
I have a deep bite	Yes ☐ No ☐		I don't like the shape of my teeth	Yes ☐ No ☐
I don't like my smile	Yes ☐ No ☐		I don't like the size of my teeth	Yes ☐ No ☐
My nose feels big for my face	Yes ☐ No ☐		I want to have a healthy mouth	Yes ☐ No ☐
I am tongue tied	Yes ☐ No ☐		I want to replace my missing teeth	Yes ☐ No ☐
I have had speech therapy	Yes ☐ No ☐		I only want to fix what is broken	Yes ☐ No ☐
I want to straighten my teeth	Yes ☐ No ☐		I want a cosmetic makeover	Yes ☐ No ☐

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Dental History and Present Illness (Confidential) **Today's Date: _____**

Patient Name _____ **Date of Birth:_____**

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Sleep Apnea			**TMJ / TMD**	
I have had a sleep study	Yes ☐ No ☐		I have TMJ problems	Yes ☐ No ☐
I have sleep apnea	Yes ☐ No ☐		I get headaches / migraines	Yes ☐ No ☐
I have a CPAP	Yes ☐ No ☐		My jaw is tired after meals	Yes ☐ No ☐
I like my CPAP	Yes ☐ No ☐		I have clicking/popping/cracking/ pain from my jaw joint	Yes ☐ No ☐
I am told that I snore	Yes ☐ No ☐		I have difficulty opening wide	Yes ☐ No ☐
I am told that I stop breathing	Yes ☐ No ☐		My jaw shifts to one side when I open or close my mouth	Yes ☐ No ☐
I am tired all the time	Yes ☐ No ☐		I have pain around my eyes	Yes ☐ No ☐
I wake up frequently at night to use the bathroom	Yes ☐ No ☐		I have ringing/hissing/stuffiness/ pain in my ears. Hearing Loss	Yes ☐ No ☐
I have memory problems	Yes ☐ No ☐		**Elective Procedures**	
I have night sweats	Yes ☐ No ☐		I want BOTOX	Yes ☐ No ☐
My child is hyperactive and / or is diagnosed with ADHD	Yes ☐ No ☐		I want FILLERS	Yes ☐ No ☐
I have GERD or acid reflux	Yes ☐ No ☐		I want VENEERS	Yes ☐ No ☐
I suffer with depression	Yes ☐ No ☐		I want a COSMETIC MAKEOVER	Yes ☐ No ☐
I suffer with anxiety	Yes ☐ No ☐		I want WHITENING	Yes ☐ No ☐
I have cardiac problems	Yes ☐ No ☐		I want INVISALIGN	Yes ☐ No ☐

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_____ _____ _____ _____

Patient, Parent or Guardian name Signature Date Time

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Today's Date: _____

INFORMED CONSENT

Appointment Times

ALL appointments are reserved for you at times that are mutually agreeable to you and the practice. If you are unable to keep a scheduled appointment, notify us immediately. We require a **24 hour** notice so that the appointment may be offered to another patient. I understand that I will be charged a $100 fee for appointments cancelled without 24 hours notice. If I miss three appointments without notice, I will be dismissed from the practice.

Please initial that you have read, understand, and consent to this paragraph: _____

Dental / Medical Records

I hereby authorize LifeSmiles to take necessary records such as study models, digital scans, photographs, radiographs, CBCT, or any other diagnostic aids deemed appropriate by LifeSmiles, its doctors and team members to make a thorough diagnosis of my condition(s). WE CANNOT OFFER YOU ANY DIAGNOSIS WITHOUT CLINICAL RECORDS. In addition to private practice, Dr. Parbhoo is an educator of doctors/ healthcare professionals worldwide. I understand and consent to the use of my clinical records, with a fictitious name, for the purpose of advertising and educating and forever release LifeSmiles and Dr. Parbhoo from any claim, demands or liability.

Please initial that you have read, understand, and consent to this paragraph: _____

Insurance Benefits

I, the patient or guardian, authorize the release of any information, including diagnosis and records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I understand that I am given treatment plans with ESTIMATES of what the insurance plan may pay. I know that I am 100% responsible for all fees not paid for by my insurance plan.

Please initial that you have read, understand, and consent to this paragraph: _____

Documents

Unless you are paying in cash, you will be required to provide a government issued photo ID.
If you are filing an insurance claim, you will additionally be required to provide a current and valid insurance card as well as a credit card for any unpaid balances past 90 days.

Please initial that you have read, understand, and consent to this paragraph: _____

_____	_____	_____	_____
Patient, Parent or Guardian name	Signature	Date	Time

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Today's Date: _____

INFORMED CONSENT

Financial Policy

1. You will be given a copy of ALL fees associated with your treatment prior to any services being rendered. We do this because you are solely responsible for 100% of fees charged.
2. Depending on the type of treatment, payment is expected either prior to, or at the time services are rendered.
3. All patients are required to keep a credit card on file, and balances past 90 days will automatically be charged to that card. Please speak with the financial coordinator if you need to make other arrangements.
4. For your convenience, we accept cash, check, major credit cards, and offer opportunities for extended financing through MoreMastercard and CareCredit.
5. **Patients with PPO Dental plans.** You are receiving a highly discounted fee for your treatment, therefore you are NOT entitled to ANY additional discounts offered by the practice. ANY balance remaining on your account past ninety days will be automatically charged to your card.

Please initial that you have read, understand, and consent to this paragraph: _____

Administrative Appointment (Non-emergency visits)

You will be scheduled for an administrative appointment for the following reasons:

1. We will review together consent forms regarding what treatment is to be rendered, risks, benefits and any but not all potential complications associated with the treatment. You will be asked to sign these consent forms ONLY after you have read them, asked questions and fully understand, and are ready to give your full INFORMED CONSENT.
2. We will review together your medical history, potential risks associated any conditions you may have and give you any necessary prescriptions.
3. We will review together ALL fees associated with your treatment. You will be expected to take care of any financial arrangements / payments at this appointment in order to reserve an appointment for your treatment.

Please initial that you have read, understand, and consent to this paragraph: _____

_____	_____	_____	_____
Patient, Parent or Guardian name	Signature	Date	Time

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Today's Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which LifeSmiles of New Hope, P.C. (referred to as "We" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care. We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

Payment. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.

Health Care Operations. We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose the information about alternative treatments.

Treatment. We may use and disclose your protected health information to assist your health care providers (doctors, dentists, pharmacies, hospitals, and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.

Plan Sponsor. If you are enrolled through a group health plan, we may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, who is usually the employer.

Enrolled Dependents and Family Members. We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health plan.

As Required by Law. We must disclose protected health information about you when required to do so by law.

Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlled disease, injury or disability.

Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies (e.g., state insurance departments) for activities authorized by law.

Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

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NOTICE OF PRIVACY PRACTICES

Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities programs.
Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

YOU'RE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Access Your Protected Health Information: You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
Right to Amend Your Protected Health Information: If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement to disagreement with our decision and we have the right to rebut that statement.
Right to an Accounting of Disclosure by the Plan: You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security proposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be at no charge. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information: You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care options. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

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Today's Date: _____

NOTICE OF PRIVACY PRACTICES

Right to Receive Confidential Communications. **You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.**

Right to a Paper Copy of This Notice: **You have the right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.**

Contact Information for Exercising Your Rights: **You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.**

Health Information Security: **LifeSmiles of New Hope, P.C. requires its employees to follow the LifeSmiles of New Hope, P.C. security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, LifeSmiles of New Hope, P.C. maintains physical, administrative and technical security measures to safeguard your protected health information.**

Changes to This Notice: **We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at LifeSmilesof newhope.com. If at any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.**

Complaints: **If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the privacy office listed at the end of this Notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.**

LifeSmiles of New Hope, P.C.
Privacy Officer : Dr. Dharmesh Parbhoo
Address: 49 Hosiery Mill Road, Suite 125
Dallas, Georgia 30157
Phone : (770) 445-1314

LifeSmiles of New Hope, PC
Dr. Dharmesh Parbhoo
49 Hosiery Mill Road, Suite 125
Dallas, Georgia 30157

Today's Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare **Provider's who may be involved in that treatment directly and indirectly.**
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician Certification's.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____ Time: _____am/pm

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initial:	Reason: