A.R. WYNNYKIW, DDS, PLLC
Progressive General & Cosmetic Dentistry

351 Osborne Road, Loudonville, New York 12211
518.432.3991
518.432.3987
smile@albanydds.com
www.albanydds.com
ARWynnykiwDDS

# Welcome!

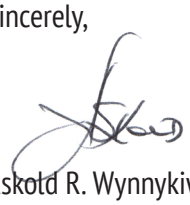
When it comes to dentists, I know that you have many options. My goal is get to know you as a whole person, and plan to do so through open and honest communication. I am very grateful that you have decided to consult me regarding your dental needs.

When I meet with new patients, my primary concern is the identification of your personal dental health **desires** and your **present condition**. In that regard, it is my intention to provide you with a superior evaluation of all aspects of function and esthetics. This **comprehensive evaluation** will include appropriate imaging and photographs, as well as an opportunity to share with me your previous dental experiences and any of your thoughts and wishes regarding your dentistry.

Why do I always conduct a comprehensive exam? Because I believe there is no "one size fits all" dentistry. **This comprehensive information will provide us (you, my team, and myself) with a basis for identifying solutions which appropriately address your reasons for visiting my practice and will assist us in being most effective in working with you according to your wishes.** In other words, it allows us to correctly understand your intentions and expectations while giving you a chance to increase your awareness of your current dental condition before any treatment options are presented.

To serve you in properly addressing your dental needs is a privilege for me; thank you sincerely for the opportunity. I look forward to seeing you soon.

Sincerely,



Askold R. Wynnykiw, DDS

**I have included a multiple page questionnaire that will assist me in getting to know you better and in being fully prepared for your visit. It may seem long, but I ask each and every question for specific and important reasons related to your oral health.**

**While I would very much appreciate having this information prior to your visit, if you would prefer completing it in person with us, please bring it along and a team member can help you (please arrive extra early).**

## Welcome!

When it comes to dentists, we know that you have many options. Our goal is to get to know you as a whole person, and plan to do so through open and honest communication.

Please fill out this form completely so that we can provide you with the best possible service.

## Today's Date

## About You

☐ MR. ☐ MRS. ☐ MISS ☐ MS. ☐ DR.

Full Name _____ (LAST / FIRST / M.I.)

Preferred Name _____

Gender _____ Birthdate ____/____/_____ Age ____

SS# ___-___-_____ Drivers Lic. # _____ State ____

Address _____

City _____ State _____ Zip _____

Email _____

Telephone: (CHECK PREFERRED)
☐ Home _____
☐ Work _____
☐ Mobile _____

Your Employer _____

Employer Telephone _____

Employer Address _____

☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

Spouse/Partner Name _____

How did you hear about us? Name of referral: _____

May we thank this person? Yes ☐ No ☐

Family members seeing us: _____

## Person Responsible for Account

☐ Same as patient (skip this section)

Name _____ Gender ____

Relationship _____ Birthdate ____/____/_____

Address _____

City _____ State _____ Zip _____

Telephone - Home _____

Work _____

Mobile _____

SS# ___-___-_____ Drivers Lic. # _____ State ____

# A.R. WYNNYKIW, DDS, PLLC

Progressive General & Cosmetic Dentistry

## Medical Contacts

| | Yes | No |
|---|---|---|
| Do you have a personal physician? | ☐ | ☐ |

Physician's Name _____

Telephone _____

Last Date of Visit _____

### Emergency Contact(s):

Please list individual(s) we may contact in an emergency.

Name _____

Relationship _____

Telephone - Home _____

Work _____

Name _____

Relationship _____

Telephone - Home _____

Work _____

## Dental Benefits

☐ I do not have dental benefits.

### Primary Insurance:

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Insured's Name _____

Birthdate ____/____/_____ Relation _____

Telephone _____

Employer _____

Policy ID or SS# _____ Group # _____

### Secondary Insurance:

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Insured's Name _____

Birthdate ____/____/_____ Relation _____

Telephone _____

Employer _____

Policy ID or SS# _____ Group # _____

A.R. WYNNYKIW, DDS, PLLC
Progressive General & Cosmetic Dentistry

## Financial Agreement

Our first priority is to provide you with advanced, highest quality dental care. Our practice depends on reimbursement from our patients for the costs incurred in their care to remain viable. We will help you to know your payment obligations in advance of treatment so that payment can be provided by you in full at the time services are rendered.

**Person responsible for account: Please read the following and sign and date at the bottom of this form.**

1. Payment is made in full on the date services are provided. Payment can be made via Cash, Check, Visa, MasterCard, American Express, Discover, CareCredit, Money Order, and Certified Check. Returned checks are subject to a $25.00 surcharge to your account.
2. We offer CareCredit to you as a financing option so that you are able to make convenient, budget-friendly monthly payments, if needed. CareCredit offers 6 and 12 month no interest plans and longer-term payment plan options with interest to its clients. We will be glad to help you apply and answer any questions you may have.
3. A 5% courtesy can be deducted from your fees for services over $300.00 should you pay by cash, check, money order, or certified check.
4. Dental Benefits: We will gladly file a claim to your dental benefits carrier as a courtesy to you. Your claims will be filed in order that the insurance carrier will reimburse you directly. All payment for services, regardless of coverage, is due in full at the time treatment is rendered. If you have not received reimbursement from your insurance carrier within 45 days of the date of service, please advise us and we will do our best to research the claim status as a courtesy to you. Note: No services are provided in this office under any assumption that an insurance carrier will provide payment. Your signature on this financial agreement serves as your agreement to allow us to file an insurance claim on your behalf.

I have read and understand the financial policy of A.R. Wynnykiw, DDS, PLLC. I understand that as the guarantor of this account, I am responsible for all fees applied to the account for treatment provided and products purchased and that these fees are expected to be paid in full at the time services are rendered. In addition, I am aware that balances over 60 days past due are subject to an 18% APR (1.5% per month) finance charge. **A 24-hour notice is required for any changes in scheduled appointments. Appointments missed or changed with less than 24-hour notice are subject to a $50.00 fee.**

Date _____ Name of Responsible Party _____ Signature _____

## Authorization to Use Photographs, Name, or Likeness

Photographs are routinely taken as part of our clinical protocol. Without this optional, signed authorization, we will not use them for other purposes.

I authorize A.R. Wynnykiw, DDS, PLLC to use clinical and portrait photographs of my face, jaws, gums, and teeth. I do not expect compensation, financial or otherwise, for the use of these photographs. I understand that you will not use my last name and will not divulge any personal information unless express written consent is obtained. I give you, for marketing and educational purposes, permission to use: ☐ **my first name** ☐ **a pseudonym**

**Educational Purposes.**
I understand that the photographs taken will be used as a record of my care, and may be used for educational purposes including but not limited to lectures, demonstrations, and publications (dental magazines, journals, professional websites, etc.).

**Marketing & Advertising.**
I understand that the photographs taken may be used in marketing materials, including, but not limited to web site publication, print marketing, and social media. I understand that when I reveal my identity and/or relationship with this practice in any public/electronic forum, including, but not limited to **Facebook** or electronic review websites, it will be considered my voluntary release of that information.

I hereby release, discharge and agree to hold harmless all persons acting on behalf of A.R. Wynnykiw, DDS, PLLC from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion of privacy.

I hereby warrant that I am of full age and have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and I am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

Date _____ Name _____ Signature _____

351 Osborne Road, Loudonville, New York 12211 518.432.3991 518.432.3987 smile@albanydds.com www.albanydds.com ARWynnykiwDDS

A.R. WYNNYKIW, DDS, PLLC
Progressive General & Cosmetic Dentistry

# Patient Medical & Dental Information

**Our Goal** is to get to know you as a whole person, and plan to do so through open and honest communication. Please fill out this form completely so that we can provide you with the best possible service.

**Today's Date** _____ **Patient Name** _____

**Do you have specific questions for the dentist?** Yes ☐ No ☐ **Why have you come to the dentist today?** _____

**What prescription or non-prescription medications are you currently taking?** Include herbal remedies and recreational drugs. _____

**Pharmacy** Name, Location, & Telephone: _____

**Please check at least one box on each line below. There are no "correct" answers!**

1. My mouth is: ☐ very comfortable. ☐ moderately comfortable. ☐ uncomfortable.
2. My smile: ☐ is excellent. ☐ is not a concern to me. ☐ could be improved.
3. My dental health is: ☐ excellent. ☐ good. ☐ fair. ☐ poor.
4. Choose one: ☐ I will do whatever I must to keep my teeth. ☐ I want to keep my teeth but only within a certain budget of time and money.
5. Choose one: ☐ In the past, I've done the dentistry recommended to me. ☐ I've not done dentistry recommended to me. ☐ Never been recommended.

| | Yes | No |
|---|---|---|
| Are you currently in any pain? | ☐ | ☐ |
| Are you under a physician's care now? | ☐ | ☐ |
| Has your physician told you that you require antibiotics before dental treatment? | ☐ | ☐ |
| Have you been hospitalized or have you had a serious illness in the last three years? | ☐ | ☐ |
| Have you gained or lost 10+ pounds in the past year? | ☐ | ☐ |
| Do you wear contact lenses? | ☐ | ☐ |
| Do you have frequent sore throats? | ☐ | ☐ |
| Do you get/have enlarged lymph nodes/glands? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Do you have any sexually transmitted infections? | ☐ | ☐ |
| Have you tested positive for HIV/AIDS? | ☐ | ☐ |
| Do you have any history of cancer? | ☐ | ☐ |
| Have you undergone radiation therapy? | ☐ | ☐ |
| Have you undergone chemotherapy? | ☐ | ☐ |

If yes to any of the above items, please list/explain:

## Allergies >> Are you allergic to or have you reacted adversely to any of the following?

| | Yes | No |
|---|---|---|
| Aspirin | ☐ | ☐ |
| Codeine | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Local anesthetic* | ☐ | ☐ |
| Penicillin | ☐ | ☐ |
| Other Antibiotics* | ☐ | ☐ |
| Latex | ☐ | ☐ |
| Sulfa | ☐ | ☐ |
| Nickel / other metal* | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Iodine | ☐ | ☐ |
| Nitrous Oxide | ☐ | ☐ |
| Milk/Casein | ☐ | ☐ |
| Chlorine/Clorox | ☐ | ☐ |
| Are you aware of being allergic to any other medications or substances?* | ☐ | ☐ |
| Do you have any food allergies?* | ☐ | ☐ |

*If yes to any of the above items, please list/explain:

## Cardiovascular >> Past or Present

| | Yes | No |
|---|---|---|
| Congestive Heart Failure | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Chest Pain/Angina | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Rheumatic Fever | ☐ | ☐ |
| Congenital Heart Defect | ☐ | ☐ |
| Prosthetic Heart Valve | ☐ | ☐ |
| Arrhythmias | ☐ | ☐ |
| Pacemaker or Defibrillator | ☐ | ☐ |
| Coronary Bypass | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Coronary Transplant | ☐ | ☐ |
| Aneurysm | ☐ | ☐ |
| Other Heart Condition (Describe): | ☐ | ☐ |

**CONTINUE ON REVERSE >>**

## Dermal/Musculoskeletal >> Past or Present

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Skin Rash | ☐ | ☐ | Connective Tissue Disorders | ☐ | ☐ |
| Night Sweats | ☐ | ☐ | Systemic Lupis | ☐ | ☐ |
| Osteoarthritis | ☐ | ☐ | Congenital Anomaly/ Genetic Syndromes | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ | Have you taken or do you currently take bisphosphonates | | |
| Artificial/Prosthetic Joint | ☐ | ☐ | (i.e. Fosamax, Boniva)? | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ | If so, for how long? | | |

## Endocrine >> Past or Present

| | Yes | No |
|---|---|---|
| Diabetes Type 1 | ☐ | ☐ |
| Diabetes Type 2 | ☐ | ☐ |
| Have you used/do you use Cortisone or other steroids? | ☐ | ☐ |

## Genitourinary >> Past or Present

| | Yes | No |
|---|---|---|
| Frequent Urination | ☐ | ☐ |
| Kidney Problem | ☐ | ☐ |
| Bladder Problem | ☐ | ☐ |
| Dialysis | ☐ | ☐ |

## Neurologic >> Past or Present

| | Yes | No |
|---|---|---|
| Vision Problems | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Earaches/Tinnitus/Ear Ringing | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Severe Headaches/Migraines Frequency: | ☐ | ☐ |
| Mild/Moderate Headaches Frequency: | ☐ | ☐ |
| Fainting or Dizzy Spells | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Anxiety/Nervousness | ☐ | ☐ |
| Panic Attacks | ☐ | ☐ |
| Phobias | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Convulsions | ☐ | ☐ |
| Psychiatric treatment | ☐ | ☐ |

## Sleep >> Past or Present

| | Yes | No |
|---|---|---|
| Apnea | ☐ | ☐ |
| Do you use 2 or more pillows? | ☐ | ☐ |

## Gastrointestinal >> Past or Present

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| GERD/Reflux | ☐ | ☐ | Cirrhosis | ☐ | ☐ |
| Stomach/Intestinal Ulcers | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Colitis | ☐ | ☐ | Eating Disorder | ☐ | ☐ |
| Persistent Diarrhea | ☐ | ☐ | Anorexia | ☐ | ☐ |
| Hepatitis A | ☐ | ☐ | Bulemia | ☐ | ☐ |
| Hepatitis B | ☐ | ☐ | Malabsorption | ☐ | ☐ |
| Hepatitis C | ☐ | ☐ | Celiac Disease | ☐ | ☐ |
| Jaundice | ☐ | ☐ | Gluten Sensitivity | ☐ | ☐ |

## Hematologic >> Past or Present

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Blood Transfusion | ☐ | ☐ | Leukemia | ☐ | ☐ |
| Anemia | ☐ | ☐ | Sickle Cell Anemia | ☐ | ☐ |
| Hemophelia | ☐ | ☐ | Excessive/Irregular Bleeding | ☐ | ☐ |

## Pulmonary >> Past or Present

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Hay Fever | ☐ | ☐ | Emphysema | ☐ | ☐ |
| Seasonal Allergies | ☐ | ☐ | Chronic Bronchitis | ☐ | ☐ |
| Sinus Trouble | ☐ | ☐ | COPD | ☐ | ☐ |
| Asthma | ☐ | ☐ | Tuberculosis (TB) | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ | Breathing Difficulties | ☐ | ☐ |

## Substances >>

| Do you use: | Now | Past | Never | List frequency and duration for each: |
|---|---|---|---|---|
| Tobacco/Cigarettes? | ☐ | ☐ | ☐ | |
| Chewing Tobacco? | ☐ | ☐ | ☐ | |
| Alcohol? | ☐ | ☐ | ☐ | |
| Recreational Drugs? | ☐ | ☐ | ☐ | |
| Intravenous Drugs? | ☐ | ☐ | ☐ | |
| Fen Phen? | ☐ | ☐ | ☐ | |

## Women >>

Are you pregnant or possibly pregnant? Yes ☐ No ☐
Are you using birth control pills? Yes ☐ No ☐
Are you nursing? Yes ☐ No ☐ If so, for how long? _____

## Other >> Past or Present

Disease/Problem/Condition Not Listed: _____

Is there any other medical or dental information that you feel your dentist should know about? ☐ Yes ☐ No If yes, please describe: _____

## Patient or Parent/Guardian

**I attest that the answers I have provided in this questionaire are true and accurate to the best of my knowledge.**

**Name** _____ **Signature** _____ **Date** _____

A.R. WYNNYKIW, DDS, PLLC
Progressive General & Cosmetic Dentistry

351 Osborne Road, Loudonville, New York 12211
518.432.3991
518.432.3987
smile@albanydds.com
www.albanydds.com
ARWynnykiwDDS

# Notice of Privacy Practices

Effective Date of Notice: September 1, 2013
Justin M. Taranto, HIPAA Officer

**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.**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

## Treatment, Payment, and Health Care Operations

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth, mouth and oral health; prescribing medications and faxing them to be filled; prescribing dental appliances and dental prostheses; showing you treatment options; referring you to another dentist for specialty care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" means those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission. We will ask for special written permission in the following situations: anything related to HIV/AIDS status.

## Uses and Disclosures for Other Reasons Without Permission

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- disclosures for law enforcement purposes, such as to provide information about someone who is, or is suspected to be, a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosures to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials;
- for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

## Appointment Reminders

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home, or send an email or text message.

## Other Uses and Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

## Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for the purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. We must honor a restriction not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to the office contact person at the address, fax, or E-mail address shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra costs. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or E-mail address shown at the beginning of this Notice.
- ask to see or get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 10 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- obtain a list of the disclosures that we have made of your health information within the past six years (or shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- obtain additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- expect to be notified in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

## Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change the Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

## Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us, or the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by the phone.

## For More Information

If you would like more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

A.R. WYNNYKIW, DDS, PLLC
Progressive General & Cosmetic Dentistry

351 Osborne Road, Loudonville, New York 12211
518.432.3991
518.432.3987
smile@albanydds.com
www.albanydds.com
ARWynnykiwDDS

## Authorization of Use and Disclosure of Protected Health Information

I authorize A.R. Wynnykiw, DDS, PLLC to use and disclose protected health information in order to carry out treatment, payment activities, and healthcare operations.

I acknowledge that I have received or have been given the opportunity to receive a copy of A.R. Wynnykiw, DDS, PLLC's Notice of Privacy Practices. This notice describes how A.R. Wynnykiw, DDS, PLLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

**Right to Terminate or Revoke Authorization:**

You may revoke or terminate this authorization at any time by submitting a written revocation to the HIPAA Compliance Officer for A. R. Wynnykiw, DDS, PLLC. I understand that revocation of this consent will not affect any action we have taken in reliance on this consent before we received your revocation.

**I understand and agree to the above terms:**

Date _____ Name of Patient _____ Signature _____

In case of minor child or patient not able to speak or act on their own behalf:

Name of Patient Representative _____ Signature _____

Relationship _____ Date _____