

*Welcome to our office and thank you for choosing us to take care of your dental health.*

*Our practice philosophy is to provide the very best health care possible in a relaxed and comfortable environment, our staff is a skilled and caring team who will work together to educate you about your present condition, your choices for treatment and your predicted results. We will also educate and empower you by explaining your responsibility for your own health. We are constantly learning the newest techniques, utilizing the finest materials and laboratories and integrating our treatment with your physician and other dental specialists. We are also very progressive in the areas of early cancer detection, medical materials and other allergy testing, customized supplementation and office computerization.*

*To enable us to provide you with this level of care, please be prepared to pay at the time of service for your convenience. We accept cash, check, MasterCard, Visa, American Express and Discover as well as Care Credit which is an affordable health care payment plan. Please remember that your insurance plan is a contract between you, your employer and their chosen insurance carrier. We are not part of that contract; our responsibility is to you.*

*Please arrive 15 minutes early for your appointment to fill out paperwork or at your scheduled time with the questionnaires filled out in their entirety. Please visit us on our website , [www.drivigs.com](http://www.drivigs.com) where you can print these New Patient Forms. We also make every attempt to run on schedule, so be prepared to be seen at the time appointed. We reserve the time for you and we will be prompt. By doing so, we will be able to respect your time as well as everyone else's. Out of courtesy for our patients and our staff, we expect you to give us at least 48 hours notice of any change of your schedule.*

*Find attached a Patient Information Sheet including your health and dental history, our federally mandated Privacy Practices Form and Patient Materials Letter.*

*If at any time you have any questions or comments, please feel encouraged to share them with us. With your feedback, we can continue to evolve to serve you even better. Again, thank you for choosing us and welcome!*

*Jeffrey S. Viglielmo, DDS, AIAOMT*

*Maureen K. Viglielmo, MS, DDS*

*Jessica Reynolds, RDH*

*Karina Fischer, RDH*

*Dagny Cleary, CDA*

*Sharon Gerber*

*Michelle Sickler*

*Sue Jacobson*

*Lynn Tetreault*

# PATIENT INFORMATION SHEET

Version 6/08

Patient's Name \_\_\_\_\_ Preferred \_\_\_\_\_ Date \_\_\_\_\_

Soc Sec # \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contacts: Please circle preferred method of contact and specify best time to call

Home Phone \_\_\_\_\_ Business \_\_\_\_\_ Cellular \_\_\_\_\_

Email \_\_\_\_\_ Referred By \_\_\_\_\_

Who will pay for this account \_\_\_\_\_ Relationship \_\_\_\_\_

**3<sup>rd</sup> PARTY REIMBURSEMENT-** We would like you to know that we do not participate with any dental insurance plan and you are expected to pay for your treatment at the time of service. We will, as a courtesy, file your claim electronically for your direct reimbursement nightly. If we encounter problems with filing, we will ask you to contact your insurance company directly. Please provide a signed insurance claim form and a copy of your enrollment card-front and back.

Primary Subscriber Information      Please circle      SELF      SPOUSE      PARENT

If not self or already on file,      Primary Subscriber's Name \_\_\_\_\_      SS# \_\_\_\_\_      DOB \_\_\_\_\_

Employer \_\_\_\_\_      Phone # \_\_\_\_\_

Address \_\_\_\_\_      City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_

Primary Insurance Carrier \_\_\_\_\_      Subscriber # \_\_\_\_\_      Group # \_\_\_\_\_

Address \_\_\_\_\_      City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_

Secondary Subscriber \_\_\_\_\_      Soc Sec # \_\_\_\_\_      Sex \_\_\_\_\_      Birthdate \_\_\_\_\_

Employer \_\_\_\_\_      Phone # \_\_\_\_\_

Address \_\_\_\_\_      City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_

Primary Insurance Carrier \_\_\_\_\_      Subscriber # \_\_\_\_\_      Group # \_\_\_\_\_

Address \_\_\_\_\_      City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_

## MEDICAL HEALTH HISTORY

The following information is essential for us to provide you with safe and effective dental care that is compatible with your health. To receive treatment in our office, all questions must be answered on this history form. Please use a blue or black pen. If a question is not understood or you are not sure how to answer it, please discuss it with the clinician. Some questions may not relate to your condition; in that event, please write N/A (not applicable). For other responses, please write YES or NO. Please elaborate if your answer is YES. To properly evaluate your current health status it may be necessary for us to contact your physician.

Please find attached our Privacy Policy Declaration which follows the Health Insurance Portability and Accountability Act (HIPAA) guidelines. It explains our safeguards to protect your confidentiality regarding any information gained from this history or during the subsequent interview and information received from other health care practitioners.

Patient's Name \_\_\_\_\_

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In the event of an emergency, who should we contact \_\_\_\_\_ Phone \_\_\_\_\_

1- Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2- Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

3- Please list any medications and/or supplements you are taking. *There are many drug and medication incompatibilities, some of which may result in dangerous health problems. This information about your current use of drugs and medications is essential.*

Name \_\_\_\_\_ Dose \_\_\_\_\_ Why \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ Why \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ Why \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ Why \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ Why \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ Why \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ Why \_\_\_\_\_

Have you had or do you have any of the following:

4- An allergic reaction to a medication (hives, itching, difficulty, breathing)? \_\_\_\_\_ If so, please describe \_\_\_\_\_

5- An adverse reaction to a medication (nausea, vomiting, other non-life-threatening reactions)? \_\_\_\_\_ If so, please describe \_\_\_\_\_

6- A need to premedicate prior to dental work? Some conditions that require this are: Rheumatic heart disease/fever; congenital heart disease/murmur; prosthetic joints, pins, plates or screws; haven taken Phen-Fen.

Write in which \_\_\_\_\_

7- If you have premedicated, what regimen have you used in the past? \_\_\_\_\_

8- Do you suffer from any disability? \_\_\_\_\_

9- Heart trouble: attack, surgery, pacemaker, angina or irregular beats? \_\_\_\_\_

10- Allergy to antibiotics, aspirin, local anesthetic or any medication? \_\_\_\_\_

11- Abnormal blood pressure, excessive bleeding or anemia? \_\_\_\_\_

12- Breathing challenges, asthma, tuberculosis, sinusitis, hay fever or any other inhalation allergies? \_\_\_\_\_

13- Liver diseases, hepatitis or jaundice \_\_\_\_\_

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14- Endocrine challenges such as diabetes or thyroid problems? \_\_\_\_\_

15- Gastric challenges, ulcers, stomach or intestinal problems? \_\_\_\_\_

16- Kidney disease or dialysis? \_\_\_\_\_

17- Nervous disorders, epilepsy, convulsions, strokes or fainting spells? \_\_\_\_\_

18- Drug dependency on alcohol, analgesics or other? \_\_\_\_\_

19- Have you ever, or are you now using illegal drugs? \_\_\_\_\_ If yes, what drugs, and when taken?

\_\_\_\_\_  
*There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and could be fatal.*

20- Joint challenges such as arthritis or rheumatism? \_\_\_\_\_

21- Cancer, tumors, growths and their treatments (surgery, radiation or chemotherapy)? \_\_\_\_\_

22- Venereal diseases or herpes? \_\_\_\_\_

23- HIV+, ARC or AIDS? \_\_\_\_\_ If yes, describe and provide current status \_\_\_\_\_

24- Do you smoke? \_\_\_\_\_ How much and for how long? \_\_\_\_\_ Snuff/chew? \_\_\_\_\_

25- Have you seen a psychiatrist, psychologist or counselor? \_\_\_\_\_

26- Had an injury to your head or neck? Describe \_\_\_\_\_

27- Are you on any special diet? \_\_\_\_\_ What kind? \_\_\_\_\_

28- Women, are you pregnant? \_\_\_\_\_ If yes, when are you due? \_\_\_\_\_

29- Women, are you using birth control pills? \_\_\_\_\_ *There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

30- Are you on have you ever taken Fosamax or any osteoporosis/osteopenia medication? \_\_\_\_\_

31- Have you been hospitalized or had a major operation? \_\_\_\_\_

\_\_\_\_\_  
32- Are there any other health challenges we should know about? \_\_\_\_\_

## **DENTAL HEALTH HISTORY**

Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

Your reason for seeing us today \_\_\_\_\_

Where may we request your dental records and radiographs?

Previous dentist's name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

Patient's Name \_\_\_\_\_

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Have you had or do you have any of the following:

33- Local anesthetic (ie. Novocaine)? \_\_\_\_\_ Any adverse reactions? \_\_\_\_\_

34- Nitrous Oxide (a.k.a. "laughing gas", "sweet air")? \_\_\_\_\_ Any adverse reactions? \_\_\_\_\_

35- Have you ever fainted or had an adverse or allergic reaction to any treatment? \_\_\_\_\_

36- Numbness or bleeding following treatment? \_\_\_\_\_

37- Do your gums bleed? \_\_\_\_\_ Have you had periodontal therapy in the past? \_\_\_\_\_

38- Any sensitivity or aching to hot/cold/sweets/pressure? \_\_\_\_\_ Looseness? \_\_\_\_\_

39- TMJ/TMD therapy or symptoms such as tooth movement, sore head & neck muscles or joints, noise when opening/closing or limitation in opening? \_\_\_\_\_

40- Do you brux (clench or grind) your teeth? \_\_\_\_\_

41- Does food catch between your teeth? \_\_\_\_\_ Where? \_\_\_\_\_

42- Growths or sores in your mouth? \_\_\_\_\_

43- Do you have any other concerns relating to your teeth or treatment? \_\_\_\_\_

44- Is there anything else we should know about you \_\_\_\_\_

**ANY CHANGES TO THE ABOVE INFORMATION SHOULD BE REPORTED TO US AT THE EARLIEST POSSIBLE TIME.**

To the best my knowledge, the foregoing questions have been accurately answered.

Print Name of person completing form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If other than patient, indicate relationship \_\_\_\_\_

**Dentist's History Review and Significant Findings**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dental office staff who reviewed history \_\_\_\_\_

Signature: Dr. \_\_\_\_\_ Date: \_\_\_\_\_

*PATIENT MATERIALS LETTER*

*Thank you for being our patient and trusting us with your dental care and health. During school and over my career, it has become clear to me that we have an obligation to treat the individual needs of each patient while also considering the whole person's systemic health. This is a more holistic or biologic approach than what was followed in the past. Our practice has always looked ahead and made changes that we have felt are in our patient's best interest. We have developed some new systems that have come to our attention through continuing education and scientific research.*

*You are being given this letter to give you some information about the treatment that has been scheduled for you. We feel that it is important to inform you of the latest theories surrounding dental materials and their safety. Most importantly, we have realized that the older, amalgam restorations leak mercury vapor which has been proven to be a health hazard since it is a neurotoxin. We no longer place this material and have not done so for a number of years. We do not feel that in the light of the knowledge that we have today, mercury should be introduced into any living organism. Legally, we cannot recommend removal of serviceable amalgam restorations since everyone is biochemically individual and some may be handling this material quite well. If, however, you are interested in doing this kind of whole mouth removal, we have literature that we will request you review before proceeding.*

*We have learned that when amalgam is removed, exposure increases unless some simple precautions are taken. What you will see is that we use a supplemental source of air for you so that you do not breathe any of the liberated mercury vapors in through your nose during the procedure. We will use a secondary vacuum equipped with a mercury vapor scavenging filter so we minimize what escapes into the air within the office. We will also use a specially designed suction tip that is more efficient in removing the metal and vapors from your mouth. A charcoal pre-rinse is available to further ensure that whatever mercury is not captured and contacts your tissues will be picked up and passed through the digestive system. We, as clinicians, will take precautions by wearing a respirator during this removal process. These steps will be taken during every amalgam removal. The treatment room is equipped with an ion generator and collection trap to further catch the mercury vapors liberated. To protect our environment outside the office, we have installed a mercury sedimentation filter on our waste water line so we do not send these metals into our global water system.*

*We have available customized nutritional supplements which can help maintain your health. It is up to you whether you feel that you want to safeguard your health with this final step. It is rather simple but obviously it is up to you so please let us know. We do have a number of publications, websites and other information about the subject. If you wish, we can consult with your physician. For those who are already systemically challenged, this is a prerequisite to proceeding with mercury removal. The first step in that process is to pass this letter along to him or her. What has been found is that due to the prevalence of mercury and other heavy metals in our environment, many of us are carrying a burden that affects our health to some degree. There are tests to determine your level of heavy metal exposure which we can discuss with you and your doctor.*

*At this point, you might now ask, if we are no longer using amalgam, what will I have placed in or on my teeth as my restoration? We have found that the newer composites are a good substitute for this earlier metal since they contain no mercury. I always will tell my patients that what you were born with is by far the best and safest material to have in your mouth and anything other than that compromises function, esthetics or systemic health. Again, science has developed specific testing that can help determine at an immunologic level which chemical groups in our environment you have developed a reaction to and which you have not. One test that I am using now is Clifford Consulting and Research's test for biocompatibility of dental materials. This test is FDA approved and more info can be found at their website at [www.ccrflab.com](http://www.ccrflab.com). From a locally drawn blood sample which is sent to Colorado, we can cross reference your individual reactivity to more than 5000 dental materials. It is a start for patients who wish to do everything available to regain their health and/or prevent future illnesses. The price is presently \$299. Having made that statement, we cannot say that all these steps will keep you well or cure you of any disease but it is the best we have today to help us "do no harm".*

*I have joined a dental society called the International Academy of Oral Medicine and Toxicology (IAOMT) which has fought worldwide to remove mercury from dental and medical offices. I am proud to be associated with this 20+ year old group which has brought together clinicians and researchers from all aspects of medicine and dentistry to educate the people of this planet to the toxins in our environment, especially ones we can avoid. Their website is [www.iaomt.org](http://www.iaomt.org) and is a great resource of information. I encourage you to check it out.*

*In closing, if you are comfortable with us placing composite as your restoration at your next visit, all you need to do is come for your appointment with this consent form signed. If you have questions about what you have read, please have these questions answered so you feel comfortable with your decisions. Call our office and let one of our front office staff know when I can return your call at a convenient time. Thank you for taking the time to read this note; we would be remiss if we did not pass along what we have learned to help you in your quest for regaining and maintaining your health.*

*Please answer a few questions by circling yes or no so we may we may better determine your level of concern around the materials we will be using and ways to safeguard your health.*

*Yes / No I feel that composite is a logical and safe choice for the direct filling material that I will have placed. I do not wish to explore any pre-restoration testing.*

*Yes / No I would like to use the charcoal to further reduce my absorption of the mercury liberated.*

*Yes / No I would like to nutritionally support my system prior to and during the removal of my amalgams. I would like information on antioxidant coverage and colon cleansing.*

*Yes / No I would like to speak to my physician before proceeding. Please call our office so that I may forward information to him/her and adjust your scheduled appointment.*

*Yes / No I would like to be tested and have a customized nutritional formulation built for me. I am requesting further information and an order form.*

*Yes / No I would like to be tested for biocompatibility of the materials to be introduced into my body. I am requesting a test kit and instructions.*

*I have read and understand that material made available to me and I have had my questions answered to my satisfaction.*

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

*Print Name*\_\_\_\_\_ *Date*\_\_\_\_\_

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

*Print Name*\_\_\_\_\_ *Date*\_\_\_\_\_

### *Notice of Privacy Practices*

*If you have any questions about this notice please contact: our privacy contact*

*Drs. Viglielmo, DDS, P.C.*

*THIS NOTICE DESCRIBES HOW DENTAL/MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*

*This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that we are permitted or required by law.*

*We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.*

#### *USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN CONSENT*

*You will be asked by your dentist to sign a consent/acknowledgment form. By signing the consent/acknowledgment form, your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your PHI (protected health information) to pay your health care bills and to support the operation of the dentist's office. Following are examples of the types of uses and disclosures of your protected health care information that the dentist's office is permitted to make once you have signed our consent/acknowledgment form.*

***Treatment:*** *We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party that has already obtained your permission to have access to your protected health information.*

***Payment:*** *Your protected dental information will be used, as needed to obtain payment for your dental services. This may include certain activities that your dental insurance plan may undertake before it approves or pays for the dental care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.*

***Healthcare Operations:*** We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

In addition, we may use or disclose your protected health information, as necessary, to contact you at your residence or place of employment. Stating the time and date of your appointment, reason and if applicable the need to pre-medicate. We may send mailings stating that you are due for treatment or a continuing care appointment. We may also call you by name in the reception area when your dentist or another staff member is ready to see you.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist practice has taken an action in reliance on the use or disclosure indicated in the authorization.

***Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.***

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your dentist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

***Others Involved in Your Healthcare:*** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your dental care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

***Emergencies:*** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your dentist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your dentist or another dentist in the practice is required by law to treat you, and the dentist attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

***Communication Barriers:*** We may use and disclose your protected health information if your dentist or another dentist in the practice attempts to obtain consent for you but is unable to do so due to substantial communication barriers and the dentist determines, using professional judgment, that you intend to consent to use or disclosure under that circumstances.

**We may use or disclose your protected health information in the following situations without your consent or authorization.**

***When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:***

***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.

***You have the right to inspect and copy your 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 members 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 dentist is not required to agree to a restriction that you request. If dentist 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. If your dentist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.*

*You have the right to request to receive confidential communications from us by alternative means or at alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.*

*You may have the right to have your dentist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices.*

*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 electronically.*

### ***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 you for filing a complaint.*

***THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON/OR AFTER APRIL 14, 2003***  
***Revised 2/08***

## PATIENT CONSENT/ACKNOWLEDGMENT FORM

*By signing below, you consent to the use and disclosure of your protected health information by Drs. Viglielmo, DDS, P.C., our staff and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Drs Viglielmo, DDS, P.C., his staff members at (845) 339-1619 and requesting a revised Notice. We will also post any revised notice in the office located at 56 Lucas Ave, Kingston, New York.*

*You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).*

*This form is also used to obtain acknowledgement of receipt of OUR NOTICE of privacy practices or to document our good faith effort to obtain that acknowledgement.*

*I have reviewed, understand, and agree to the content of the Notice of Privacy.*

*NAME \_\_\_\_\_ DATE \_\_\_\_\_*

*Signature of Patient/Legal Guardian of Minor*

*PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT/ACKNOWLEDGEMENT OF NOTICE OF PRIVACY*

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