Welcome.

Congratulations on your decision to undergo one of the most thorough oral health evaluations available. Our approach to your dental health is very different from the approach you will find at most dental practices.

Philosophy.

Our philosophy can be summed up with one single statement: "Know your patient." This individualized and personalized approach to dental care starts with a thorough new patient examination that provides us with the opportunity to learn about our patients' values, desires, and fears. It also gives us a chance to understand how to effectively communicate with each and every one of our valued patients.

Our goal is to help patients achieve naturally beautiful smiles that are designed to last many years. Our dentists and team members believe that patients who play an active role in achieving and maintaining their oral health will be more successful in achieving the level of health they are seeking.

We also believe strongly in the relationship between oral health and total body health. Our practice welcomes new patients who are willing to become active participants in their oral health.

How to keep in touch.

This will be your first step towards our professional engagement in assuring that you receive optimal individualized care.

It is our goal that you find this experience exceptional, not only from a preventive health perspective, but also from an educational and service delivery point of view. By completing the enclosed Medical History Form and Dental History Form thoroughly and accurately, you can help us make your visit efficient and effective.

We realize that this history will require some time to complete. We will review this information so that we can anticipate your medical and dental needs prior to your first visit.

Please complete the forms in their entirety and send them back to our office at least one week prior to your appointment.

There are several options for how you can complete and return these forms:

- You can write the answers in the blank form and either mail or fax it to our office
- If you prefer, we can send you a digital copy that you can complete on your computer and e-mail to our office
- You can access these forms on our website, www.kogandmd.com, under the "New Patient" navigation link

Important Contact Information

Phone	440.646.1133
Fax	440.646.1335
E-mail	kogandmd@sbcglobal.net
Website	www.kogandmd.com
Mail	29001 Cedar Road, Suite 404, Lyndhurst, OH 44124

Our team looks forward to serving you!

The comprehensive examination.

We provide our new and existing patients with a "comprehensive" education regarding their unique oral health care needs, in addition to any systemic or quality of life implications that their current state of health and well-being may reflect. *We believe that the comprehensive examination is the most valuable service we provide to our patients.*

There are numerous components that affect our complex masticatory (chewing) system that are important to understand, and it is necessary to *thoroughly* examine our patients in order to fulfill our obligation to them as their restorative dentist. We pay attention to detail, as this is the only way we can provide our patients with customized, leading edge care.

Therefore, it is important that our patients partner with us as *active* participants in their treatment, and allow us to take ample time to examine the head and neck musculature, the temporomandibular joints (TMJs), occlusion (the way our teeth come together), periodontal status, aesthetic analysis, and a detailed medical, dental, and social history in order to understand our patients more clearly. We take very detailed and thorough records and photographs in order to provide our patients with the most appropriate and well-planned treatment options for their individual needs, goals, and desires.

After analysis of the information obtained during our comprehensive co-discovery examination together, we invite you to a review of findings consultation. During this consultation, we will educate and discuss any potential risk factors or problems along with corresponding recommended treatment solutions that are most appropriate for you and your circumstances.

We have found this approach to optimize outcome and minimize emergencies. It is only by supporting our patients needs that we ensure our success, and we strive to pursue excellence by continually improving and raising the bar in every aspect of our practice.

We understand, unfortunately, that this may be a radical departure from other dental practices that schedule new patients for a dental prophylaxis ("cleaning") before meeting the doctor and having an appropriate comprehensive examination. This approach is unsuitable for our standards of excellence that we demand from ourselves, so please realize how important it is for us to get to know you in order to build a rewarding, long-lasting, meaningful relationship.

--

Please allow approximately **two hours** for your initial comprehensive examination appointment. Should the examination require more time, we will kindly invite you to return at a subsequent appointment to finish our comprehensive examination.

Dental practice types.

As with any profession, there is a tremendous amount of care, skill, and judgment in dentistry. Though there are many variables, a dental practice usually falls into one of the following four categories regarding the care that is offered:

> ***Type 4: Emergency*** (10-15% of practices) - Patients are only seen for emergency care, and do not value their teeth. This type of practice has no philosophy and is filled with doctors and patients who could care less, just as long as the problem (aka tooth) goes away.
>
> ***Type 3: Reactive and Repair-Oriented*** (60-70%) - This is the vast majority of dental practices. No long term thought is given to a patient's oral health and there is a "fix it" type mentality similar to a carpenter or plumber. There is a strong focus on tooth-by-tooth dentistry, and the practice is usually heavily insurance-based, and incredibly busy as a result. This type of practice may have all the latest technology to increase efficiency and production, but that does not always translate to better care. Interestingly enough, most patients aren't necessarily happy in this type of practice, but have either lost hope or have grown accustomed to this level of care.
>
> ***Type 2: Maintenance and Conformative Dentistry*** (15-20%) - This type of practice has good quality of care and an increased focus on education and prevention but patients are not completely committed to optimum care. The dentistry is better than average, but may break down faster because treatment was not ideal. Patients are made aware of all problems and understand what their treatment options are for their situation.
>
> ***Type 1: Fine Dentistry and Prevention*** (Top 5%) - Patients are dedicated to achieving optimal oral health through comprehensive care and excellent home care. This type of practice focuses on the "big" picture and understands the mouth as a system and how it relates to one's overall health. The dentist has a "philosophy" for the way he/she cares for people. Individualized plans are developed for each patient after understanding their circumstances and objectives. There is a strong emphasis on understanding "why" things may be happening before jumping into treatment. The dentistry is technically sound, appropriate for each specific patient and usually lasts much longer because of the amount of thought that went into it.

Please note that we draw line between type 2 and type 3 dental practices. Our practice is not an "emergency only" or repair-oriented (aka "drill, fill and bill") type of practice. We strive to be a Type 1 or 2 practice and would like to treat people who understand and appreciate that our number one priority is you and your health.

We take pride in listening to you, getting to know you and doing what's best to enable the long-term comfort, function, esthetics and health of your entire masticatory system. In order for us to truly enjoy our practice and find meaning behind our work, we believe in treating people who value their health, share our vision and trust, and appreciate the care, skill and judgment of Dr. Kogan and our team.

We would be delighted to have you join our practice and experience the difference.

About dental insurance.

Every dentist must choose the way he or she decides to practice. We have made the choice to see one patient at a time, give them our undivided attention, and allow enough time to do the procedure right – the first time – so there are no return visits to deal with the problems of rushing a procedure in an attempt to see another patient.

Doing dentistry in a safe, healthy, biocompatible way requires an immense amount of care, skill, and judgment from the restorative dentist. It requires that our doctors and team members take the highest quality continuing education and implement the most predictable systems to deliver our dentistry beautifully and predictably.

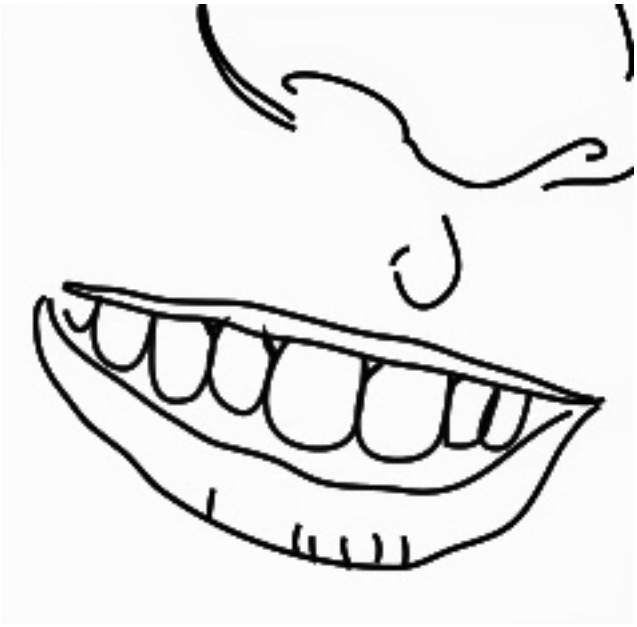
Being an insurance network provider would not allow us to do that.

Many of our patients have dental insurance, which covers a portion of the fees for quality dental services. While most of us have medical insurance policies that evolved from "major medical" insurance, dental insurance plans always have a schedule of fees, based on the average in your area, as well as an annual cap on the maximum reimbursement. Recognize that all insurance companies have different reimbursement allowances based simply on what the employer negotiates with the insurance company.

Your insurance CAN be used here, we will submit the claim for you along with any necessary documentation and they will reimburse you.

We value the relationships and trust developed with our patients and will always provide you with the finest possible care without regard to any limitations of your insurance.

We have *many* patients who choose our practice despite what their insurance tries to tell them to do.



The Role of Dental Insurance in Our Practice

As a relationship-based dental practice and team of dedicated healthcare professionals, we strongly believe in providing our patients with the absolute best dental care possible regardless of whether your insurance covers it or not. In effort to maintain our commitment to the highest quality of care, we would like you to understand some basic information regarding dental insurance and our philosophy.

1. Your dental insurance is based upon a contract between your employer and an insurance company. While we do our best to help you with your benefits, **ultimately it is your responsibility to understand them.**

2. **Dental insurance benefits are completely different than medical insurance**. Your dental insurance maximum is the exact same amount now as it was in 1970. Assuming inflation, the $1000-1500 max that you receive today should be closer to $6000 per year in benefits. Insurance companies don't tell you that. Instead, they continually raise premiums, keep benefits the same (or even downgrade) and lower the reimbursement rates. As a result, we view your dental benefits strictly as an aid to help lower the cost of dental care.

3. Many companies will tell patients that they are covered up to 80-100%, but do not take into account your plan's specific fee schedule allowance, annual maximums, waiting periods, limitations and other fine print. **It is more realistic to expect dental insurance to cover 25-60% of selected services.** Please keep in mind that the amount a plan pays is determined by how much your employer paid for the plan. You only get what your employer put in, less the profits of the insurance company of course.

4. Many routine dental services are NOT covered by insurance companies**.** We do not file any predeterminations because we have experienced numerous inaccuracies and false expectations in doing so. **We will do our best to estimate your coverage, but keep in mind it is only our best guess and you will be held responsible for any services provided that your insurance did not cover.**

5. We are committed to providing you with the absolute best dental care possible delivered in a courteous and professional manner. **We genuinely care about your health and well-being and your insurance company does not**. Please keep that in mind when making choices regarding your health.

6. If you are unable to afford our dentistry**, but desire this level of care and believe that we are the right practice for you**, we would be happy to try and make confidential financial arrangements that will fit into your budget.

By signing below, I have read and understand the role of dental insurance in this practice. I will make every attempt to make choices based on my health and well-being. In return, I understand that Dr. Kogan and his team will make every attempt to deliver a level of care and service that exceeds my expectations.

_____ _____

Signature of Patient/Guardian Dr. Matthew D. Kogan

_____

Date

KOGAN + KOGAN
AESTHETIC | RESTORATIVE | IMPLANT

Our Promise:
The primary goal of Kogan + Kogan Dental, Inc. is to provide high-quality, relationship-based dental care in a safe and comfortable environment. We strive to maintain the highest standards through patient education and service, professionalism, compassion, efficiency, and continuing education. Our team is eager to help you with your dental needs, and is committed to forming long-lasting relationships built around trust with all of our patients. We are honored that you have chosen us and will make every effort to exceed your expectations.

Patient Initials _____

Office Policy:
We recognize that your time is valuable, and will make every effort to stay on time. We also understand that life can be unpredictable at times and "things happen." **If the need to cancel a scheduled appointment arises, we kindly request 24 hours notification.** Appointments cancelled within 24 hours, or a "no-show" appointment, may result in a $50 charge to your account and/or loss of certain scheduling privileges. In efforts to provide our undivided attention, we ask that cellphones be silenced in all treatment areas.

Patient Initials _____

Insurance Policy:
As a courtesy, we will be happy to file all claims with your insurance company directly. We will do our best to estimate your deductible and portion not covered by your insurance, and this amount will be due **at the time of service**. If our estimates differ from your insurance company, then the difference will be either credited or billed to your account accordingly. **All procedures not covered by insurance are ultimately your responsibility** and any denied insurance claims will automatically be billed to your account. We are a third-party provider, and will not enter into any disputes with your insurance company, as your coverage is an agreement between the insurance and your employer.

Patient Initials _____

Financial Policy:
Payment for all services rendered is expected **at the time of your appointment**. For your convenience, we accept cash, personal check, Visa, MasterCard, Discover, and American Express. Any returned checks will result in a $25 processing fee. If an extended payment plan is desired, please ask us about our financing options. We also offer a 5% discount (3% with credit card) on all major treatment plans if paid for in-full prior to starting treatment. Unpaid balances over 30 days are subject to a 1.5% interest fee. Any delinquent accounts over 90 days may be referred to a collection agency, and all fees incurred while doing so will be billed to the account. I hereby assume full financial responsibility for all treatment rendered, whether or not paid for by my insurance, and authorize my insurance benefits to be paid directly to Dr. Kogan. In addition, I authorize the use of my signature and release any information required for the processing of my claims.

Patient Initials _____

Patient Signature _____ Date _____

Print Name _____

Consent to digital dental photography and video.

In order to provide optimal care and exceptional dentistry, Dr. Kogan may utilize digital dental photography for any of the following reasons:

- Dental records
- Patient education
- Dental research
- Communication with interdisciplinary team (specialists)
- Communication with laboratory technician (ceramist)
- Dental education including lectures, seminars, demonstrations, and professional publications (i.e.: journals)
- New patient education (including websites, printed materials, blog)

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name (first name only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:

_____ I do not mind if my first name, face, and teeth are used in any of the above stated situations.

Exceptions:

_____ I do not wish to have my First Name shown, or released.

_____ I do not wish to have my face shown.

_____ I only agree to have my teeth shown without any identifying features.

_____ I do not wish to have my photos used at all.

Patient Name _____

Patient/Guardian Signature _____

Date _____

KOGAN + KOGAN

AESTHETIC | RESTORATIVE | IMPLANT

Patient Information

Today's Date _____ Date of Birth _____

Name _____ Social Security # _____

Address_____

City_____ State_____ Zip _____

Home # _____ Cell Phone # _____

Email Address_____

Preferred contact method (please check one): Home Cell Email

Employer's Name _____ Work # _____

Employer's Address _____

Emergency Contact Name_____

Relation _____Emergency Contact Number_____

Person Financially Responsible _____

How did you hear about us? _____

Whom may we thank for referring you? _____

Dental Insurance Information

Primary Dental Insurance Carrier_____

Subscriber Name_____ Subscriber Birth Date_____

Subscriber Employer_____

Policy Holder's Social Security # _____

Subscriber ID _____ Group #_____

*** Please notify us if you have any secondary insurance coverage ***

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Notice of Privacy Practices Acknowledgement

I understand that, under Health Insurance Portability and 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 providers, 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 certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address (29001 Cedar Road Suite 404, Lyndhurst, Ohio 44124) to obtain a current copy of the Notice of Privacy 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_____

****

Office use only
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date:_____Initials:_____Reason:_____

NOTICE OF PRIVACY PRACTICES (DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to receive an accounting of disclosures of protected health information.
• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of this day, this month and this year we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

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4. Many routine dental services are NOT covered by insurance companies**.** We do not file any predeterminations because we have experienced numerous inaccuracies and false expectations in doing so. **We will do our best to estimate your coverage, but keep in mind it is only our best guess and you will be held responsible for any services provided that your insurance did not cover.**

5. We are committed to providing you with the absolute best dental care possible delivered in a courteous and professional manner. **We genuinely care about your health and well-being and your insurance company does not**. Please keep that in mind when making choices regarding your health.

6. If you are unable to afford our dentistry**, but desire this level of care and believe that we are the right practice for you**, we would be happy to try and make confidential financial arrangements that will fit into your budget.

By signing below, I have read and understand the role of dental insurance in this practice. I will make every attempt to make choices based on my health and well-being. In return, I understand that Dr. Kogan and his team will make every attempt to deliver a level of care and service that exceeds my expectations.

_____ _____

Signature of Patient/Guardian Dr. Neil J. Kogan

_____

Date