Seth A. Shapiro D.D.S. • Dari P. Shapiro D.D.S.

SHAPIRO FAMILY DENTISTRY

WELCOME TO OUR PRACTICE

On behalf of our staff and ourselves it is with great pleasure that we welcome you as a new patient to **Shapiro Family Dentistry.** We are very pleased that you have chosen our office for your dental needs and we feel that this will be the beginning of a long and satisfying dental relationship. Our goal is to keep with your expectations and provide the highest quality of dental care. You can always expect to be treated as part of our family when visiting us.

We are a family-oriented dental practice and offer the most-up-to-date and comprehensive dental treatment to our patients in the Palm Beach County area. What is unique about our practice is our personal quality care. Our first priority is your comfort. We consider your personal needs first and your choices will be respected. It is our desire to provide for all of your dental needs realizing that complete dental health comprises not only the elimination of existing dental diseases, but the ultimate goal of prevention.

Dentistry has seen dramatic changes over the last few years. New materials and techniques have given us the means to perform services quickly, painlessly and in a manner that is cosmetically pleasing. We can place crowns, partial dentures and implants to restore functions where some teeth are missing or where there are no teeth at all. Cosmetically we can work magic with techniques that restore broken teeth to their natural state in one visit. We can straighten teeth without unsightly braces and bleach teeth an average of 6 shades lighter. Best of all, you get your smile back and once you look good, you feel good.

Each of our staff has been trained in specific dental specialties and will treat you, the patient, as needed. In order to make you feel more comfortable each doctor also has trained in residency specialties such as implantology, oral surgery, endodontics, and prosthodontics and continuing education in sirona technology, and invisalign (invisable orthodontics), and therefore will individually treat you in this office, in most cases, rather than referring you to another office.

We encourage you to take advantage of our expertise in providing our family of patients with the highest quality of care. Our multi-specialty framework enables us to achieve efficiency and consistency in an optimal setting for our patients.

If at any time you have any questions about your treatment or appointment please feel free to contact "Angel" and she will be glad to address any concerns you may have.

We value and respect every one of our patients and when a patient doesn't show up for an appointment another patient who is often in pain and needed to be seen has to be turned away in order to accommodate you. Because we value our patients and their time, we reserve the right to charge for a failed appointment. A failed appointment to us is when you do not show for a scheduled appointment, you call the same day to cancel, or you call and leave a message on our answering machine. **The missed appointment fee is $50.00.**

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FINANCIAL POLICY

It is your responsibility to inform our office of any address and telephone number changes. Your account is to be kept current; all self-pay or insurance co-payments will be collected at the time of service. **We submit your claim as a courtesy; however, we must emphasize that as a dental provider our relationship is with you, the patient, not your insurance company.**

Your signature below indicates that you have read and understood the above.

_____ _____

Your signature **Date**

We look forward to a long and healthy dental relationship with you!

Dari Shapiro DDS
Seth Shapiro DDS

DENTAL INSURANCE

Shapiro Family Dentistry practices quality dentistry. We will treat you as we would treat ourselves. We will provide you with a plan of treatment prior to your procedures, and will make every reasonable attempt to estimate your copayment. Unfortunately, this is only an estimate and you must be aware of the following:

1. Most insurance plans have deductibles;
2. There may be contractual changes between the insurance company and your employer;
3. Your insurance company may not pay for the best treatment; for instance they may pay for metal crowns and not porcelain crowns on your back teeth, and they will not pay to replace teeth missing prior to coverage;
4. Some insurance companies pay for 2 cleanings a year, others 1 cleaning every 6 months and a day;
5. Although it has been shown that the mercury in silver have been classified as potentially dangerous, some insurance companies will pay for only mercury fillings on back teeth. **We feel this is wrong and may affect our patient's health and therefore do not place mercury fillings**;
6. Some insurance plans have waiting periods (some up to 2 years) before they will pay for anything but a simple cleaning;
7. Some insurance representatives fail to provide the correct information, others refuse to fax benefits or coverage verification to our office for our records and most refuse to tell us when your last treatment at another dental office occurred;
8. Although x-rays are diagnostic and necessary and payable at 100% with no deductible by some insurance companies, the same company will not pay 100% and apply a deductible;

We hear time and time again: "my insurance pays for everything." This is not true. And we did not choose your insurance company, nor are we employees of your insurance company. This office will submit your claim as a courtesy to you. We will send necessary documentation and x-rays when requested. If your insurance company fails to pay your claim within (30) days, you will be responsible for payment in full. Please remember your insurance company is a business and wants to make a profit.

I have read and understand the above and acknowledge responsibility of payment should my insurance company fail to pay my claim for any reason.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Print Name **Relationship to Patient**

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PORCELAIN AND RESIN FILLINGS

Dear Patient:

As a provider of dental services we wish to clarify that we are an "**amalgam free**" office. Amalgam free **means we do not do "silver fillings."** (ADA codes 2140-2161).

Resin composites (natural tooth colored fillings) and porcelain inlays and onlays are not a covered procedure under some dental plans on rear teeth (molars or stress bearing surfaces of premolars). The insurance company guidelines states (such as Aetna DMO, DC37 and others) that "any non-covered procedure may be charged to you, the member, at full fee".

If during the course of your dental treatment it becomes necessary to have a tooth filled, with resin, onlay, or inlay we will advise you accordingly. Because we do not offer an alternative treatment for resin composites or use inlays and onlays to save tooth structure in special circumstances, we will extend a courtesy discount off of our usual and customary fees per tooth.
Your signature below on this memo indicates that you acknowledge and understand that Shapiro Family Dentistry does not perform silver fillings (amalgams) and that you have elected to receive resin composite fillings instead of silver if and when you are ever diagnosed with a cavity that can be restored by "filling" it.

Signature Patient/Guardian_____

Witness_____Date_____

INSURANCE BILLING

Shapiro Family Dentistry has adopted an office policy due to the extensive amount of time and paperwork involved in insurance billing. Shapiro Family Dentistry will continue to submit claims as a courtesy, however, if we fail to receive payment within 30 days from your insurance company we will then bill you directly including collection costs if applicable. Payment will be due 14 days from the date of your statement. Due to Florida requirements regarding disposal of biomedical waste and the costs required to comply with this requirement our office charges an infection control fee to cover the necessary time, paperwork and costs to comply with this Statute including removal of biomedical waste for the protection of our patients. We will invoice your insurance company accordingly.

We adhere to all fee schedules as a contracted provider for insurance plans and you must understand that your carrier may pay less than the actual amount submitted. You agree to be responsible for payment of all services rendered on your behalf and on the behalf of your dependents and agree by your signature below that you assign all insurance benefits to Shapiro Family Dentistry, if any, otherwise payable to me for services rendered, and that you authorize your signature on all insurance submissions on your behalf. I further authorize Shapiro Family Dentistry to charge my credit card for any deficiency after payment from my insurance company.

Your signature below indicates acceptance of this policy accordingly. I have read the above and agree to the terms stated therein.

Signature Patient/Member/Guardian_____ Date_____

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PANOREX X-RAY

THE PANOREX X-RAY IS USED TO DIAGNOSE ABNORMALITIES AND INFECTIONS OF THE JAWBONE AND FACE.

THIS X-RAY PROVIDES A TWO-DIMENSIONAL IMAGE OF YOUR MOUTH AND EXPOSES PARTS OF YOUR JAW AND FACE THAT CAN NOT BE SEEN WITH TRADITIONAL DENTAL X-RAYS. IT GIVES US A VIEW OF THE ENTIRE UPPER AND LOWER JAW INCLUDING THE TEMPOROMANDIBULAR JOINT (TMJ), THE NASAL SINUSES AND THEIR SURROUNDING BONE. IT ALSO SHOWS THE MANDIBULAR NERVE, WHICH PROVIDES SENSATION TO THE TEETH AND GUMS OF THE LOWER JAW. IT IS USED FOR THE EARLY DETECTION OF ORAL CANCER WHICH MAY NOT BECOME EVIDENT UNTIL IT'S ADVANCED. A PANOREX X-RAY MAKES IT EASIER TO SEE CYSTS AND TUMORS IN THE JAWBONE WHETHER BENIGN OR MALIGNANT. IT HELPS THE DENTIST LOCATE FRACTURES AND TRAMA TO THE JAW BONE, AND IN CHILDREN DETERMINES WHETHER THE PERMENANT TEETH ARE DEVELOPING PROPERLY BENEATH THE PRIMARY TEETH. IT IS USED TO SEE THE LOCATION AND ANGLE OF THE WISDOM TEETH AND HOW THEY ARE AFFECTING THE TEETH IN FRONT OF THEM.

THEREFORE, THE PANOREX X-RAY IS AN INTERGRAL PART OF THE PATIENT EXAMINATION.

THE PANOREX X-RAY IS NOT AS PRECISE AS THE USUAL DENTAL X-RAYS AND THERERFORE IT IS STILL NECESSARY TO TAKE THE USUAL DENTAL X-RAYS TO CHECK FOR DENTAL PROBLEMS PERTAINING STRICTLY TO THE TEETH AND SURROUNDING STRUCTURES SUCH AS CAVITIES OR PERIODONTAL DISEASE. INSURANCE COMPANIES MAY OR MAY NOT PAY FOR BOTH TYPES OF X-RAYS AND SOMETIMES COMBINE THE BENEFITS FOR THESE PROCEDURES EVEN THOUGH THEY ARE NOT THE SAME. I UNDERSTAND THAT SHOULD THIS OCCUR I AGREE TO BE RESPONSIBLE FOR PAYMENT OF THE BALANCE NOT COVERED BY INSURANCE.

I HAVE READ AND UNDERSTAND THE ABOVE.

PATIENT:_____ DATE:_____

PATIENT'S GUARDIAN:_____ DATE:_____

PRINT NAME OF PERSON SIGNING:_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____ Social Security No.:_____

Address:_____

Telephone:_____ E-Mail:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING CAREFULLY

Purpose on Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures me may make of your protected health information. A copy of this Notice accompanies this Consent for you to take with you. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices which will contain the changes. These changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practice including any revision at any time by contacting us by phone or by mail at the above address.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand revocation of this Consent will not affect any action we took in reliance on the Consent prior to receipt of you revocation and that we may decline to treat you or continue treating you if you revoke this Consent.

I _____(print name) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____(signature) _____(date)

If this consent is signed by a personal representative on behalf of the patient complete the following:

Person's representative's name:_____

Relationship to Patient:_____

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YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE A COPY OF THIS COMPLETED CONSENT IN THE PATIENT'S CHART
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, _____have received a copy of this office's Notice of Privacy Practices.

_____(print name)

_____(signature) _____(date)

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgment of receipt of Notice of Privacy Practices. Acknowledgment was unable to be attained because:

_____Individual refused to sign;

_____Communication barriers prohibited obtaining the acknowledgment;

_____An emergency situation prevented us from obtaining acknowledgment;

_____other(please specify below)

_____patient was given a copy of Notice of Privacy Practices

_____

_____

_____

_____(signature of staff member) _____(date)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 1, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our used of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we can not use or disclose your health information for any reason except those described in this Notice.
To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose your health information to military authorities of the armed forces under certain circumstances. We may disclose to authorized federal authorities/officials health information required for lawful intelligence, counter-intelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders such as voicemail messages, postcards or letters.

PATIENT RIGHTS

Access: You have the right to view or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we can not practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies we will charge you .99 cents for each page, $ n/a per hour for staff time to locate and copy your health care information, and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure. Duplication of x-rays are $25.00.

Disclosure accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 5 years but not before April 14, 2003. If you request this accounting more than once in a 12 month period we may charge you a reasonable cost-based fee for responding to these additional requests. Shapiro Family Dentistry has adopted an office policy due to the extensive amount of time and paperwork involved in insurance billing. Shapiro Family Dentistry will continue to submit claims as a courtesy, however, if we fail to receive payment within 30 days from your insurance company, we will then bill you directly including collection costs if applicable. Payment will be due 14 days from the date of your statement. Due to Florida requirements regarding disposal of biomedical waste and the costs required to comply with this requirement our office charges an infection control fee to cover the necessary time, paperwork and costs to comply with this Statute including removal of biomedical waste for the protection of our patients. We will invoice your insurance company accordingly. Some insurance companies request invoicing for crowns (2750/6750 and other dental procedures associated with laboratory fees), on insertion dates, some (Cigna) on preparation dates, and some (Metlife) plans on insertion or preparation depending on the plan. In light of the above, and the difficulty ascertaining which date to use, this office will unilaterally invoice your insurance company on the preparation date as this is the date the laboratory fee is incurred. If you do not have insurance we will invoice you on day of impressions for any laboratory work. We adhere to all fee schedules as a contracted provider for insurance plans and you must understand that your carrier may pay less than the actual amount submitted. You agree to be responsible for payment of all services rendered on your behalf and on the behalf of your dependents and agree by your signature below that you assign all insurance benefits to Shapiro Family Dentistry, if any, otherwise payable to me for services rendered, and that you authorize your signature on all insurance submissions on your behalf. I further authorize Shapiro Family Dentistry to charge my credit card for any deficiency after payment from my insurance company.

Administrative Fee: Section 466 of the Florida Statutes requires that "patient records kept in accordance with this section shall be maintained for a period of 4 years from the date of the patient's last appointment." This office charges an administration fee which covers the necessary time, paperwork, and storage facilities, to comply with this Statute and the operation of this facility including the preparation and furnishing of all paperwork necessary under provisions of the statute and applications for licensing to operate radiographic equipment (x-rays), renewal and payment of all licenses, state, county and city fees, and required reports and credentialing requirements for the operation and continued compliance of this dental office, and/or removal of biohazardous waste, and infection control, and sterilization monitoring and the increased cost of dental products due to the new Federal Excise Tax. Should any patient wish to review the results of our sterilization monitoring tests please call office manager at (561) 684-2282 and she will make them available to you. This fee is charged on EACH APPOINTMENT.

I have read and understand the above Administrative Fee. _____

Your signature

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (you must make your request in writing) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must specify why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have any questions or concerns please contact us. If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: Office Manager
Telephone: (561) 684-2282
Facsimile: (561) 328-6217
Address: 2247 Palm Beach Lakes Blvd. West Palm Beach, FL 33409