MANOR COLLEGE

700 Fox Chase Road
Jenkintown, PA 19046
215.885.2360
215.576.6564
manor.edu

MANOR DENTAL HEALTH CENTER

WELCOME

On behalf of the entire staff, welcome to our office. We are pleased that you have selected us to care for your dental needs. We want you to know that we are committed to providing you with the highest quality of oral health care in the most gentle, efficient and enthusiastic manner possible.

The highest degree of sterilization and infection control standards are observed in our facility in order to safeguard your health.

Our primary goal, whenever possible, is the retention of your healthy, natural teeth. To accomplish this aim, we need your cooperation. We believe that an informed patient is better motivated to maintain his/her oral health. We will keep you informed of our diagnosis and recommended treatment at all times. We encourage you to ask questions regarding your dental health and your treatment at Manor Dental Health Center.

The Manor Dental Health Center was established primarily as an adjunct to the Expanded Function Dental Assisting (EFDA) program in order to provide students with supervised training in their chosen profession. The benefits are numerous. Not only does the student receive extraordinary experiences while working directly with the dentist, but the patient becomes the recipient of quality dental care.

While under the care of a staff dentist, you will notice that our students are providing many treatment procedures for you. This is to say that the EFDA may be performing reversible oral procedures such as placement of fillings and fabrication of temporary crowns. This is being done under direct supervision of the dentist who is primarily responsible for your care. We trust that your experience with us will be pleasant as well as informative. We are here to serve you.

DENTAL SERVICES

The Dental Health Center provides:
Diagnostic (x-rays, examinations and consultations)
General Dentistry (filings, etc.)
Oral Hygiene (cleaning and preventive care)
Orthodontics (Braces)
Oral Surgery (extractions)
Limited Prosthodontics (removable and non removable replacements of missing teeth)
Periodontics (Non surgical treatment)

If your general dentist or hygienist recommends that you seek the services of a periodontist, you will be referred to a periodontal specialist.

Orthodontic services are provided by a board certified orthodontist. This treatment is reserved for patients 18 years of age and under.

DENTAL INSURANCE

Dental insurance is intended to cover some, but not all of the cost of your dental care. Most plans include co-insurance, a deductible and other expenses which must be paid by the patient.

If you have dental insurance, please bring your plan information with you to your fist visit. We will work with you to assure that you receive the maximum benefits to which you are entitled.

OFFICE HOURS

Our Dental Health Center hours are:

Monday	9 a.m- 9 p.m
Tuesday	9 a.m- 5 p.m (Orthodontics)
Wednesday	9 a.m- 9 p.m
Friday	9 a.m- 4 p.m

Please call **215-887-7617** during office hours so that an appointment can be scheduled.

We want to serve your dental needs. If you have any questions concerning the Dental Health Center or the EFDA Program, please do not hesitate to ask any of our staff members.

SPECIAL NOTE

Due to this center being operated by the college, we are closed when the students are not in session. Please be advised during this time treatment cannot be rendered by the Dental Health Center staff. We will try to accommodate your immediate emergency needs by referring to a local dentist.

Transportation

Manor Dental Health Center is easily accessible by public transportation. (SEPTA bus #28, Huntingdon Valley Transit Company, SEPTA Fox Chase and Jenkintown train stations and automobile from the NE Philadelphia and the Montgomery and Bucks County Suburbs).

PATIENT REGISTRATION

Patient Name (Last) (First) (MI)	Home Phone: Cell:
Mailing Address Apt#	Patient Date of Birth:
City State Zip	Email address:
Occupation Employer Name	Marital Status: Single Married Other
In Case of Emergency Notify: Name: Phone:	

MINOR PATIENT or GUARANTOR INFORMATION

(If Patient is a minor or dependent, please complete this section)

Mother's Name and Address	Day Phone	Evening Phone	Guarantor □
Father's Name and Address	Day Phone	Evening Phone	Guarantor □

In an effort to know more about the patients we serve, we would appreciate the following information:
**This information helps to gain grant funding, keeping patient costs at a minimum.*

Race: □ Black/African American □ White/Caucasian □ Asian □ Hispanic/Latino □ Decline to State
□ Pacific Islander □ American Indian/Alaskan Native □ Other

Household Income: (Please check) **Number of people in household:_____**

□ under $20,000 □ $20,000 - $40,000 □ $40,000 - $60,000 □ $60,000 - $80,000 □ $80,000 - $100,000 □ over $100,000

DENTAL INSURANCE INFORMATION (if applicable)

PRIMARY DENTAL INSURANCE:
Subscriber Name: **Subscriber ID#**
Date of Birth:
Relationship to Subscriber: □ **Self** □ **Spouse** □ **Child** □ **Other**
Employer Name: **Phone:**
Insurance Company: **Ins. Co. Address:**
Insurance Group # **Insurance Phone:**

I authorize Manor College Dental Health Center or my insurance company to release any information required for payment or review of this claim. I am financially responsible to Manor College Dental Health Center for all balances due and assign my benefits to Manor College dental Health Center

_____ _____

Patient/Guardian Date

MANOR COLLEGE DENTAL HEALTH CENTER

MEDICAL AND DENTAL HISTORY

Patients Name:_____ **Date:**_____

	YES	NO		YES	NO
Vision problems			Thyroid problems		
Wear contact lenses			Kidney problems		
Hearing problems			Arthritis: Osteo/Rhuematoid		
Wear a hearing aid			Artificial Joints: Date _____		
Asthma: Stress or allergy induced?			- Antibiotic Premedication recommended by surgeon		
Sinus problems			Epilepsy		
Allergies/Hay fever			Fainting/dizzy spells		
Hives of skin rashes			Neck/back problems		
Tuberculosis			fibromyalgia		
Persistent cough			Cancer: type _____		
COPD			- Chemotherapy		
Emphysema			- Radiation therapy		
Shortness of breath			- Surgical intervention: Date___		
High/low blood pressure			- Mastectomy: Side: _____		
Heart attach/angina			Chemical dependency		
Blood thinners/aspirin therapy			Alcohol dependency		
Heart defect or murmur			Nervousness/anxiety/depression		
Mitral valve prolapse			Mental health care		
Congenital heart problem			Acid reflux/GERD		
Stroke			Ulcerative colitis/IBS		
Swelling of feet, ankles or hands			Crohn's disease		
Prosthetic heart valves			Hiatal hernia		
Pacemaker/defibrillator			Stomach ulcers		
Heart surgery/catherization			Eating disorders		
Rheumatic or scarlett fever			Bisphosonate medications		
Took fen-phen drugs			**Men only**		
Anemia			- Do you take Viagra?		
Diabetes Type 1 or 2			**Women only**		
- Insulin dependent			- Are you pregnant?		
Hypoglycemic			- Due date:		
Blood disorders			- Are you nursing?		
Clotting problems			- Are you taking birth control pills		
Hepatitis/what type_____			- Are you taking any hormones		
HIV/AIDS			Other conditions not listed above		
Sexually transmitted disease					

OVER

MEDICATIONS	ALLERGIES
List any medications (ex. Coumadin) you currently take, including over the counter drugs, supplements and herbals: **Medications /Dose** **Reason for taking** _____ _____ _____ _____ _____ _____	**Please circle those that apply to you:** Penicillin Iodine Sulfa Latex Tetracycline Nuts Aspirin Codeine **Other**: **Do you carry an Epi Pen?** Yes No
Pharmacy name and Phone number:	

DENTAL HEALTH HISTORY

Reason for today's visit_____

Date of last dental visit:_____ **Date of last xrays:**_____

How often do you brush?_____ **How often do you floss?**_____

Please circle if any pertain to you:

Wear dentures Mouth pain/sores Jaw pain/clicking Bite cheek/lips Bite fingernails

Broken teeth/fillings Loose teeth Grind/clench teeth Bad breath

Mouth breathing Dry mouth Sensitive to hot/cold/sweets Sensitive to biting

Bleeding gums Swollen gums Use tobacco products

Have you ever had Orthodontic Treatment(braces)? Yes No

Have you ever had Periodontal Treatment(gums)? Yes No

Patient Signature: _____ **Date :**_____

Doctor Signature: _____

MANOR COLLEGE

Dental Health Center Code of Conduct for Patients, Parents, and Visitors

MISSION: Manor College believes that personalized education in the Judeo-Christian tradition generates a commitment to a peaceful world, which inspires confidence in the present and hope for the future. Manor's Basilian environment enables students to fully develop as individuals and instills an understanding of scientific, humanistic and ethical principles so students form a global vision. Manor also believes that graduation begins a new chapter of lifelong learning.
By maintaining academic excellence through current, innovative programs and encouraging students to develop a sense of inquiry, their critical thinking, effective communication skills, and by providing opportunities to serve the community, Manor graduates are prepared to serve society effectively and compassionately.
PURPOSE: To ensure that Manor's students and patients receive the best care, Manor College expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.
GUIDELINES: The following behaviors are prohibited:

- Possession of firearms or any weapon.
- Physical violence, physical assault, arson, or inflicting bodily harm.
- Making verbal threats to harm another individual or destroy property.
- Intentionally damaging equipment or property.
- Making menacing gestures.
- Attempting to intimidate or harass other individuals.
- Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communications (including social media).
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality.
- Fraternizing with Manor students. Manor students are not permitted to date patients.
- Unwanted advances of a sexual nature, sexual harassment, sexual misconduct, sexual violence.
- Requests for what would constitute illegal or unethical behavior by Manor College students or staff.
- Children left unattended or unsupervised.
    - Parents and Guardians are equally liable for the damages and/or harms attributed to the conduct of an unsupervised or unattended child.
    - For the purposed of this Code of Conduct policy, "unsupervised" also includes when the patient or guardian of a child is the patient of the Dental Health Center.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

I agree to abide by Manor College's "Code of Conduct for Patients, Parents, and Visitors"

_____ _____
Patient's Name Date of Birth

_____ _____
Caregiver's Name/Relationship to Patient Date

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MANOR COLLEGE
EXPANDED FUNCTIONS DENTAL ASSISTING PROGRAM

GENERAL INFORMATION AND CONSENT FORM

Thank you for becoming a patient of the Manor College Dental Health Center. Your support of our Dental Health Center is beneficial to both the students, as well as you, the patient. Your participation is vital to our educational process.

As a patient, you are entitled to considerate, respectful and confidential treatment that is completed in a timely manner and meets the standard of care for the profession. You are also entitled to an explanation of findings and recommended treatments which include: alternatives, cost, the option to refuse treatment, the risk of not proceeding with the recommended treatment and the expected outcomes of various treatments. If you feel you have not received any of this information, you may contact the EFDA Program/DHC Director.

As a patient, you should also be aware of the following:

1. Treatment in the Dental Health Center proceeds more slowly than in a private office since services are rendered by faculty dentists in conjunction with EFDA students. All procedures performed by students are carefully monitored and evaluated by Manor faculty.
2. The Dental Health Center reserves the right to refuse to provide treatment if the patient does not or will not accept recommended treatment and procedures, including radiographs. Radiographs (x-rays) will be taken based on patient need. The Dental Health Center also reserves the right to refuse to provide treatment if the patient's medical condition contraindicates routine dental treatment. Only patients who meet the learning needs of our students, as deemed appropriate by the dental and EFDA faculty, will be accepted as Dental Health Center patients.
3. Non-compliance of treatment, referrals and diagnostic procedures such as x-rays, will lead to dismissal of treatment at Manor's Dental Health Center.
4. Twenty-four (24) hour notice of cancellation is required by the patient. A $25.00 fee will be charged for non-compliance.
5. Patients should arrive promptly for their scheduled appointments.
6. Due to emergencies, scheduled appointments may be delayed. All patients will receive appropriate care and time required for optimum treatment.
7. All records are property of Manor Dental Health Center. Duplicates of x-rays may be sent to an office for referral or transfer purposes. A $10.00 charge for duplication will be administered for transferring patients.
8. All fees for services such as restorations (fillings), prophylaxis (cleaning), radiographs (x-rays), exams, build-ups, post and cores, bleaching and extractions are due at the time of procedure. Fees for multiple visit procedures such as crowns and bridges, inlays and onlays, veneers and partials, are divided into multiple payments with final payment due on delivery.
9. Fees are subject to change at the discretion of Manor Dental Health Center due to increases of cost of materials and lab fees. All efforts will be made to keep fees down.
10. A written medical clearance may be necessary if the dentist warrants a need due to elevated blood pressure, heart condition, patients on blood thinners, uncontrolled diabetes, artificial joint replacements or any other medical condition that my affect dental treatment.
11. Written premedication verification from a patient's physican will be required before dental treatment at Manor Dental Health Center. Conditions such as artificial joint replacement, kidney dialysis, organ transplants or any

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other condition requiring premed according the the AHA, AJA and AMA guidelines. Prescription for premed needs to be obtained by treating physician.

12. The College may have photography or videography for marketing purposes.

Having carefully read the above, I verify that I understand that information herein and I grant authority to Manor College Dental Health Center to perform those procedures deemed necessary. I give permission for release of my records to and from my dentist and/or physician and/or insurance company. I also agree to make payments for services in accordance with the treatment plan.

Printed Name of Patient	Witness Signature
Signature of Patient or Legal Guardian	Date

Manor College
Expanded Functions Dental Assisting Program
DENTAL TREATMENT CONSENT FORM

Patient Name_____ Date_____

Please read and initial all items below and sign the section at the bottom of the form.

1. **POSSIBLE WORK TO BE DONE**
   I understand that I may have the following work done. Fillings, bridges, crowns, extractions, local anesthesia, root canals, other. (Initials _____)
2. **DRUGS AND MEDICATIONS AND LATEX**
   I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). For women, antibiotics may alter effectiveness of birth control pills. (Initials_____)
3. **CHANGES IN TREATMENT PLAN**
   I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make an/all changes and additions as necessary. (Initials_____)
4. **REMOVAL OF TEETH**
   Alternatives to removal will be explained to me (root canal therapy, crowns and periodontal surgery, etc). I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials)_____)
5. **CROWNS, BRIDGES AND CAPS**
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size anda color) will be before cementation. (Initials_____)
6. **DENTURES: COMPLETE, PARTIAL AND IMMEDIATE**
   I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances will be explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures are considered transitional, therefore a new set of dentures may be required after healing and shrinkage is complete at an additional charge. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)
7. **ENDODONTIC TREATMENT (ROOT CANAL)**
   I realize that complete endodontic treatment is not performed at the DHC and a referral will be given for such treatment. A dentist at his/her own discretion may perform initial treatment and/or prescribe medication to alleviate pain. (Initials_____)
8. **PERIODONTAL LOSS (TISSUE AND BONE)**
   I understand that I may have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans will be explained to me, including non-surgical procedures to be performed here. Surgical procedures will be referred to an outside facility/office. I understand that undertaking any dental procedures may have a future adverse affect on my periodontal condition. (Initials_____)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian_____ Date_____
(if patient is a minor)

9/02; 1/28/10

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MANOR DENTAL HEALTH CENTER

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 take effect 11/25/2015 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records and metal health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management and determinations of eligibility and coverage to obtain payment from you, insurance or another third party. For example, we may send claims to your dental health plan containing certain health information.

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

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat your with respect to your health information.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall , repair or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Worker's Compensation. We may disclose your PHI to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and credentialing as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications. To opt out, contact Manor College's Director of Development.

Other Uses and Disclosures of PHI. Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

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Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request that we place additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing,. Your request must specify the alternative means and location, and provide explanantion of how your payments will be handled under the alternative means and 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 explain why the information should be amended. We may deny your requestunder certain circumstances. If we agree to you request, we will amend your records and notify you of such.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by email.

Emails. Notify individuals that we do not encrypt emailed PHI.

Questions or Complaints. If you want more information about our privacy practices or have questions or concerns, please call us.
If you are concerned that we may have violated your privacy rights, or if you disagree with the 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 also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file a complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of health and Human Services.

Contact Officer: Lisa Pizzica **Telephone**: 215-887-7617

Fax: 215-885-6084 **E-mail**: lpizzica@manor.edu

Address: 700 Fox Chase Road, Jenkintown, PA 19046

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

8/2015

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MANOR COLLEGE DENTAL HEALTH CENTER

HIPAA CONTACT CONSENT FORM

We understand that medical information about you and your health is personal and we are committed to protecting it. In order to comply with the HIPAA (Health Insurance Portability and Accountability Act) privacy notice of 1996, we are requesting that you designate to whom we may disclose specifics of your health information (ie: laboratory an radiology results, necessary follow-up appointments).

Which is the primary number you want us to contact you at:

_____ ( )H ( ) C ( )W

Can we leave you a message on your machine at this number:

_____Yes, call back number only

_____Yes, okay to leave detailed message

_____No

If you are not available, is there a family member with whom we are authorized to speak?

1. Name:_____ Relationship_____
2. Name:_____ Relationship_____

Print Name:_____Signature_____Date:_____

03.07.17