NILOOFAR MOFAKHAMI, D.D.S., PLLC
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OAKTON, VA 22124

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 THIS NOTICE 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 has been in effect since April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and 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 at 703-255-3424.

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 and disclose your health information to obtain payment for services we provide to you.

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

Your Authorization: In addition to our use 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 cannot 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 the 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 this 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 our health or safety or the health or safety of others.

NILOOFAR MOFAKHAMI, D.D.S., PLLC

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 Practice.

_____
Please Print Child's Name

_____
Signature of Parent/Guardian

_____
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
- ○ Communication barriers prevented us from obtaining acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (please specify)

_____
_____
_____
_____

Signature_____Date_____

-TURN OVER -

2/2005

Niloofar Mofakhami, DDS, PLLC
Office Policies and Financial Agreement

Our goal is to provide the highest quality dental care at an affordable cost for all of our patients. Please read over the following policies and discuss any special circumstances so that we can work together as a team to complete all necessary treatment for your child. Please initial each item below.

____ Payment, including deductibles, co-payments, and non-covered services, is due when services are rendered.

____ We will file an insurance claim if you are a subscriber of Delta Dental, MetLife, or United Concordia and accept payment from these companies on your behalf. Any applicable deductibles and co-payments will be collected at the time of service.

____ If you are a subscriber of any other PPO plan, we will complete a dental claim as a courtesy and send it on your behalf. We collect our payment at the time of service, and your insurance company will reimburse you directly. Please provide us with your insurance information so that we can help minimize your paperwork.

____ Please note that some insurance plans do not cover the cost of white (composite resin) fillings in full. They will only pay for the silver (amalgam) fillings. It is the patient's responsibility to pay the minimal difference. We only place composite fillings in our office.

____ We appreciate at least a 24-hour notice if you are not able to keep your child's appointment. There will be a $50 fee for missed appointments without a 24-hour notice. We understand that emergencies come up. Please inform us as soon as possible so that the appointment will be available for other children who need our help.

____ Any outstanding balances greater than thirty days must be paid in full immediately or a collections fee of $75 and appropriate action will be taken to recover these funds.

____ Returned checks from insufficient funds will incur a $25 fee.

_____There is a $5.00 transfer of records fee. Please allow 5 business days for obtaining records.

I have read the office policies and financial agreement and agree to the terms.

_____
Signature

_____
Printed Name

_____
Date