Name:____
Address: ____ City: _____________ St: ______ Zip: __________
Home Phone: ______________________ Cell Phone: _____________________ Work Phone: ___________________
Occupation:____ Date of Birth: _______/_______/__________
Would you like to receive e-mails about our spa specials? Yes No
E-Mail Address: _________________________________
Who may we thank for referring you? _______________________

Area of complaint or tension: ____
____

The following information will help to anticipate your personal needs.
Please place a √ in the circle to indicate YES to a condition or concern:

○ Insomnia	○ Arthritis	○ Diabetes	○ High blood pressure	○ Cancer
○ Skin problems	○ Chest pain	○ Heart condition	○ Low blood pressure	○ Edema
○ Neck pain	○ Stomach problems	○ Headaches	○ Menstrual pain	○ Sciatica
○ Varicose veins	○ Broken bones	○ Bulging disc	○ Herniated disc	○ Dizziness
○ Claustrophobia	○ Extremity numbness	○ Pregnancy	○ Contact lenses	○ Allergies

Are there any additional health issues or concerns?
____

Do you have any body regions that should not be massaged?
____

If pain is a concern for you, please complete:
Location of pain: ____ Pain with motion? Yes No
What makes pain better? ____
What makes it worse? ____

During your treatment, your therapist will use various approved techniques to massage the necessary body parts to facilitate your treatment, excluding any contraindicated areas. The therapist will not work the breast area during your treatment. Proper draping will be used throughout your treatment.

I release The Hills Dental Spa from any responsibility for pre-existing conditions I have not revealed, or any consequential changes to these conditions that arise subsequent to the treatment. Massage therapy is never a substitute for medical examination and diagnosis. It is recommended that I see a physician for any medical ailment that I might have and understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorders.

Client Signature ____________________________________ Date: ____________

Therapist Signature _________________________________ Date: ____________

Benjamin L. Nemec, DDS

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 carefully. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices. Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make:

Treatment - We will use and disclose your protected health care information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health care information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment - Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations - We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the front desk where you will be asked to sign your name when you arrive. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

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

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

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

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

Other Permitted and Required Uses and Disclosures that May be Made with Your Consent, Authorization or Opportunity to Object

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

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgement to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.

Other Permitted and Required Uses and Disclosures that May be Made without Your Consent

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

Emergencies: We may disclose your health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement of Receipt of Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care.

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 the health or safety of others.

Military Activity and National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance.

Your Rights

You have the right to inspect and copy your protected health information. You have the right to look at 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 cannot practically do so. You must make the 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 a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you prefer, we will prepare a summary of an explanation of your health information, for a fee.

You have the right to request a restriction of your protected health information. You have the right to request that we place additional restrictions on our use and 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 an emergency.

You have the right to request alternative communications from us. You have the right to request that we communicate with you about your health information by an 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.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain explanations, restrictions and limitations. 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.

You have the right to make a complaint about our privacy policies. If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the end of this Notice. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this Notice electronically.

Privacy Practices effective: March 28, 2003

Privacy Officer: Amie Nemec Telephone: 512-423-7825 Fax: 512-347-9844
E-Mail: Amie@TheHillsDentalSpa.com Address: 6836 Bee Caves Road, Suite 110, Austin, Texas 78746

Benjamin L. Nemec, DDS
6836 Bee Caves Road, Ste. 110 | Austin, Texas 78746 | 512.347.0044
www.TheHillsDentalSpa.com

Acknowledgement of Receipt of Notice of Privacy Practices

I, _______________________, have received a copy of Dr. Nemec's Notice of Privacy Practices.
(print name)

____
Signature

Date: __________

For Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

___ Patient refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other reason: ____
____
____
____