Jonathan Rudner, DDS
Cosmetic Dentistry

PATIENT INFORMATION & PRACTICE AGREEMENT

We would like to extend a warm welcome to our practice, where helping you obtain a healthy, beautiful smile is what we love to do best! We are a full-service cosmetic and general dental practice where all procedures are performed with an artistic eye and from an aesthetic point of view. We are committed to making sure your visits with us are comfortable and enjoyable.

FULL NAME:____PREFERRED NAME:___________________

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?____

BIRTHDATE:____________________SOCIAL SECURITY #:____

□ MALE □ FEMALE □ GENDER NEUTRALITY □ SINGLE □ MARRIED

CURRENT MAILING ADDRESS:____

____

E-MAIL ADDRESS:____

CONSENT TO COMMUNICATE ELECTRONICALLY VIA TEXT/E-MAIL PERTAINING TO APPOINTMENTS, TREATMENT, AND SCHEDULING:
□ YES □ NO

CELL PHONE:__________________________ WORK PHONE:____

WHAT IS YOUR PREFERRED FORM OF COMMUNICATION?____

OCCUPATION:_______________________________ EMPLOYER:____________________________________

FINANCIAL RESPONSIBLE GUARANTOR:____

PHONE NUMBER:____

INSURANCE COMPANY:______________________________ GROUP/POLICY#:__________________________

SUBSCRIBER ID#:___________________________________ SUBSRIBER DOB:__________________________

EMERGENCY CONTACT NAME:_________________________ RELATION TO YOU:________________________

PHONE NUMBER:____CELL NUMBER:____________________

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MEDICAL HISTORY

Are you currently under the active care of a physician or do you have any present health issues? □ YES □ NO

If yes, please explain:____

Do you need to pre-medicate with antibiotics for any heart or other conditions before dental treatment? □ YES □ NO

Are you taking any prescription or over the counter medications (including ibuprofen, Diet supplements, etc.)?
□ YES □ NO Please list each one:____

____

Are you pregnant or nursing? □ YES □ NO / Do you smoke? □ YES □ NO If so, how much daily?_____________

Are you allergic to (Please check all that apply): □ ASPIRIN □ CODEINE □ DENTAL ANESTHETICS □ ERYTHROMYCIN
□ SULFITES □ LATEX □ PENICILLIN □ TETRACYCLINE □ ANY METALS □ OTHER: ___________________________

____

Do you drink alcohol? □YES □ NO , If so, how much daily? ____

Please check all that apply:

□ ARTHRITIS
□ BLODD TRANSFUSION
□ CANCER/CHEMOTHERAPY
□ DIABETES
□ FAINTING
□ HEART ATTACK
□ HEART SURGERY
□ HERPES/FEVER BLISTERS
□ PACEMAKER
□ SEIZURES
□ THYROID
□ ARTIFICIAL BONES/ JOINTS/ VALVES
□ CONGENITAL HEART DEFECT
□ ULCERS
□ EMPHYSEMA
□ FREQUENT HEADACHES
□ HEART MURMUR
□ HEPATITIS ____ TYPE
□ HIGH BLOOD PRESSURE
□ RADIATION TREATMENT
□ SHINGLES
□ TUBERCOLOSIS
□ ASTHMA
□ HIV/AIDS
□ HPV
□ KIDNEY PROBLEMS
□ LIVER DISEASE
□ LOW BLOOD PRESSURE
□ LUPUS
□ MITRAL VALVE PROLAPSE
□ RHEUMATIC/SCARLET FEVER
□ SICKLE CELL DISEASE

Please list any significant medical condition(s) or surgeries you have had (not listed above):________________________

____

The information I have provided on this form is accurate and complete to the best of my knowledge, information and belief. I will notify the practice at the soonest practical moment of any changes in the information I have provided. In consideration of being accepted as a patient of the practice, I agree to abide by the terms and conditions of this patient application & practice management.

SIGNATURE:____ DATE:_________________

JONATHAN RUDNER, DDS
COSMETIC DENTISTRY

Patient-Dentist Arbitration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would be determined by submission to arbitration as provided by California Law, and not by a lawsuit, or resort to court process, except as California law provides for judicial review or arbitration proceedings. Both parties of this contract by entering into it, have given up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:
The term “patient” as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.
The term “doctor” as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.
B. Treatment Covered:
Patient understands and agrees that any dispute of the sort descried in Article I between doctor and patient will be subject to compulsory, binding arbitration.
C. Coverage of Pre-Natal Claims (If Applicable):
Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort descried in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.
Article III.

A. Informal Resolution of Disputes:
In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running or statute of limitations for ninety (90) days.

B.
B. Method of Initiating Arbitration:
If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.
C. Applicable Law:
The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.
The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator’s decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.
The prevailing party shall be entitled to attorney fees.

Article IV.
Revocation:
If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL, SEE ARTICLE I OF THIS CONTRACT.

PATIENT’S NAME: (Please Print):____________________ PATIENT SIGNATURE:____________________

DENTIST’S SIGNATURE:____________________ WITNESS SIGNATURE____________________

DATE:____________________

JONATHAN RUDNER, DDS
COSMETIC DENTISTRY

Notice of Privacy Policy

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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgment and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Research:** We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).
- **Other Authorizations:** 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 authorization, you may revoke it 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.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

PATIENT RIGHTS

- **Access:** 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 practicably do so. You must make a request in writing to obtain access to your health information.
- **Records:** We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.
- **Accounting of Disclosures:** 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 6 years. 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.
- **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be required to agree to these 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 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 must explain the reason for the amendment.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address 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 HHS.
HIPAA Coordinator: Paris Madani
Telephone: (310) 226-8181
Email: info@rudnerdds.com
Address: 450 North Bedford Drive, Suite 214 Beverly Hills, CA 90210

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Signature:____

Patient Name:______________________________________

Patient Representative (if minor):____________________________

Date:____________________

Witness:________________________________

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, MasterCard, Visa, Discover, American Express and CareCredit.

Dr. Rudner is not a preferred provider with any dental insurance plan. For those patients covered by a PPO dental insurance, we are happy to extend the courtesy of billing your insurance company for reimbursement to you. However, in order to provide this service to you, we must have complete and accurate insurance information. It is your responsibility to fill out the necessary forms that give us all the insurance information required. It is your further responsibility to follow up with your insurance company in a timely manner should payment have not been received.

Please understand due to the nature of our dental practice, we do not do any payment plans in office, you are welcome to apply for CareCredit or other interest free credit cards to use for your services at our office.

Cancellation Policy

Missed Appointment (s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 48 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice. A charge of $100 will be applied to your account in violation of the above policy for hygiene appointments and up to half of your treatment total scheduled based on 2 or more hours of appointment. Should the cancellations fees go unpaid over 90 days, your account will be forwarded to collections and daily finance charge of 1.5% plus collection fees will apply.

Please keep in mind that you are responsible for your appointments, our office will give you reminders as a courtesy and in no way is obligated to do so. Please be respectful of our office policy and we will in return be respectful by always seeing you on time.

JONATHAN RUDNER, DDS
COSMETIC DENTISTRY

REQURED - CREDIT CARD:

In order to secure an appointment time a credit card must be left on file. The card that is provided will ONLY be charged if your appointment is cancelled outside of the requested 48-hour policy. However, unless communicated otherwise your card may also be used for Copayments, Deductibles, Payment Plans, and Services Rendered.

Name as it appears on the Card: ____

Type of card: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: ____

Expiration Date: _______ /________

Security Code: _____________________

I understand and agree that payment for dental services, and appointment responsibility in this office for myself and/or dependents is mine. I authorize this card to be used for the maintenance of my account, as well as the above terms and conditions.

SIGNATURE:____ DATE:____________________________