HIPAA COMPLIANCE AUTHORIZATION PATIENT CONSENT FORM

Darrin J. Violi, DMD

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Unless you provide us in writing that you refuse, you agree that this office can share needed information about your treatment plan with your referring dentist and/or family physician and/or a dentist/physician that you are being referred to.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, attorneys, collection agencies, law enforcement officials, worker's compensation, etc.), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You, as the patient, have the right to receive one free copy of your medical records.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restriction, and to revoke consent in writing after you have reviewed our privacy notice. I acknowledge that I have received a HIPAA Compliance Assurance Notification from the office of Darrin J. Violi, DMD.

Print Name:_____ **Signature:**_____ **Date:**_____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative Name:_____

Relationship to the Individual:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients: The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us to prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!

VELscope Oral Cancer Exam
Patient Consent Form

Oral Cancer has become the sixth leading cancer among men and is one of the few cancers in which the rate of detection is increasing among young adults. Most people are not aware of the potential risks; however, when detected early enough, the survival rate for oral cancer is very high.

Dr. Violi has always conducted a visual comprehensive oral cancer screening for all of our patients, but we have recently incorporated a breakthrough technology that will allow us to see things we've been unable to see previously. By detecting potential problems earlier, we'll be providing our patients with the best oral health care currently available.

This new and exciting technology, called VELscope™, utilizes a narrow band of safe, high-energy blue light and specialized filtering technology to help thoroughly evaluate the oral tissue for abnormal areas of concern, such as potentially cancerous lesions that may not be evident under white light. The VELscope™ has successfully improved the identification of pre-cancerous abnormalities in thousands of exams of squamous epithelium of the cervix and has recently been cleared by the FDA for an oral application.

We are now offering this screening to all patients during their consultation. We believe that this new technology will assist us in detecting disease at earlier stages and therefore catch abnormalities before they turn into cancer.

This exam is not a new procedure, but most insurance companies **do not** cover the procedure cost. There is a fee of $29 for using this tool to aid in the examination of your oral tissue. If you have any questions about the VELscope, feel free to ask during your appointment.

For our records, please indicate below whether or not you wish to have the VELscope exam:

Yes please, I authorize Dr. Violi to use the VELscope oral cancer screening along with my conventional visual oral exam. I accept financial responsibility for this enhanced visual exam since the procedure is not covered under my insurance.

Print name: _____

Signature: _____ Date: _____

No thank you, I would prefer not to have the VELscope oral cancer exam:

Print name: _____

Signature: _____ Date: _____