NOTICE OF PRIVACY PRACTICES — CONTINUED

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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 for each page, $30.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we. will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: 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 iast 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, costbased 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 are not 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 it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a 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 also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your 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.

QUESTIONS AND COMPLAINTS BK DENTAL CONTACT OFFICER

Boris Kaltchev DMD
Email: staff@bkdental.com
Address: 140 E. Commercial Street, Wood Dale, Illinois 60191

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a Notice of Privacy Practice from the practice of Boris Kaltchev, DMD PC, BK Dental LLC and/or BK Dental-Evanston, LLC.

CONSENT FOR PHOTOGRAPHY

I, _____, hereby consent that photographs and x-rays taken of me by the practice of Boris Kaltchev DMD PC, BK Dental LLC and/or BK Dental-Evanston, LLC may be used for any of the following purposes:

1. For inclusion in my dental record.
2. For BKDental.com websites, office displays or brochures.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays. study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date_____

Parent/Responsible Party's Signature _____ Relationship to Patient_____

Witness_____

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Borislav Kaltchev DMD PC, my dental-health care provider, to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all medical and dental health benefits due to me and my dependents.

I authorize payment to Boris Kaltchev DMD PC, BK Dental LLC and/or BK Dental-Evanston LLC, the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

I also authorize Dr. Kaltchev, or his staff, to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays and photographs) about my medical/dental history, or about services rendered or treatment given to me or my dependents, that is needed to review, investigate or evaluate any claim or benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective while I am a patient of record of Boris Kaltchev DMD PC, BK Dental LLC and/or BK Dental-Evanston LLC.

A photocopy of this authorization may act as an original.

I know that I have a right to receive a copy of this Authorization and Acknowledgment if requested.

Signature of Patient or Insured_____ Today's Date_____