Nancy Norling
1660 South Hwy 100 #122
MInneapolis
Minnesota, 55416

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Nancy Norling understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 takes effect 11/16/2017, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the 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 using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, 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 another 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 use or 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 that 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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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 your health or safety or the health or safety of others.

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

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, mailing, 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 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 last 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, 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 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 at 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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Kathy Mathews
Telephone: 9525444129
E-mail: mrskmat@gmail.com
Address: 1660 South Hwy 100 #122
Zip Code: 55416
State: Minnesota
City: MInneapolis

NANCY NORLING DDS

Consent for Use and Disclosure of Health Information and Verbal Release

I, _____ _____, have received and reviewed a copy of Dr..Norling's Dental Office Notice of Privacy Practices and Security Policies and Procedures.

Signature_____Date_____

Patient Consent Form for Use or Disclosure of Patient's Protected Health Information.

This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.

Name_____ Date of Birth_____

I hereby authorize Dr. Norling and/or members of her staff to release the following Personal health information: 1) Dental services claims information. 2) Prescriptions, Diagnostic, treatment, and/or care management services 3) Review required by HHS or HIPAA-compliant health care operations. 4) Communications from the dental office by telephone, email, fax, postal services or any means that the office feels efficient to contact me regarding the above mentioned statements.

My Consent Effective: Today's Date_____

Continue Indefinitely: I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patients rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient_____Date_____

Personal Representative_____Date_____

If there are other persons or entities that you would like us to be able to speak to about your care please list below

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

OK to leave message containing confidential information on voicemail to this and/or these numbers:

HOME_____ CELL_____ WORK_____

FORM A Smile Assessment Questionnaire

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Dentistry

NAME_____

1. If there was anything you could change about your smile, what would it be?

2. What is your reason for the appointment?

3. In our work together, what are your goals and objectives?

4. What qualities are you looking for in a dentist?

5. What role does your insurance coverage have in achieving your objectives?

6. What do we need to know about you in order for us to work well together?

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1. Do you like the color of your teeth? Y / N
2. Would you like to change the way your teeth or gums are shaped? Y / N
3. Do you have gaps or spaces between your teeth that you would like filled in? Y / N
4. Are your upper front teeth straight? Y / N
5. Are your lower front teeth straight? Y / N

FORM D Finance Policy

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Our commitment is to inform you of the fees for all dental treatment. At your request we will submit pre-estimates to your insurance company when applicable. We also offer affordable payment plans through Care Credit Co. and will make available application forms when needed. The following is our financial policy:

A. All cosmetic dentistry appointments will require full payment on the day of the appointment.
B. Major treatment appointments (crowns, onlays and bridges) will require one-half down at the time of the appointment and balance at completion. **If you have insurance we will be happy to process your claim and your insurance company will reimburse you directly.**
C. Preventive treatment appointments (cleanings, exams, x-rays and sealants), restorative appointments (fillings), and periodontal treatment appointments (gum disease, root planing and scaling) will require payment at the time of the visit**. If you have insurance we will be happy to process your claim and your insurance company will reimburse you directly.**
D. Method of payment:

1. Cash, personal checks
2. Visa, MasterCard, American Express or Discover
3. Care Credit health card (please inquire with our office manager)

I am aware that Dr. Norling is a non-participating provider for all network insurance plans. This means that if my dental insurance plan allows me to go out of network to see the dentist of my choice, my out of pocket expense will be higher than seeing a participating provider. If you have questions we ask that you contact your insurance company or your employer.

Patient Signature:_____Date_____

FORM C Dental Treatment Consent

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I hereby authorize Dr. Nancy Norling and her assistants to perform the following dental treatment plan. If any unforeseen condition arises in the course of treatment calling for procedures in addition to, or different from those now contemplated, I wish to be informed and involved in the decision for alternative treatment.

I am informed and fully understand that inherent in any type of dentistry includes the possibility of unavoidable complications. I am aware that the practice of dentistry is not an exact science. I do not hold Dr. Nancy Norling responsible for any common complications of dentistry. This may include teeth sensitivities, the need for endodontic treatment, TMJ problems, and gingival or mouth tissue sensitivities. I further realize that in spite of the possible complications, my contemplated dental work is desired by me.

I realize that it is mandatory that I give an accurate and complete medical history, and follow all instructions as directed by Dr. Nancy Norling to ensure optimum results from my dental treatment.

The following dental procedures may be included in my treatment plan:

- Dental examination
- Dental x-rays
- Diagnostic photographs
- Prophylaxis
- Fluoride treatment
- Sealants
- Restorative treatment
- Cosmetic treatment
- Periodontal treatment
- Endodontic treatment
- Oral surgery
- Orthodontic

Any questions about my proposed dental treatment have been fully answered. I have read this statement and understand it completely.

Parent/Guardian/_____ Signature_____ Date_____

Doctor_____ Signature_____Date_____

PATIENT REGISTRATION

Today's Date_____

Patient First Name: _____ Patient Last Name: _____ Middle Initial:_____

Preferred Name: _____

Patient is : □ Responsible Party

Responsible Party: (Responsible Party is policy holder and/ or parent/ guardian of patient)

Patient First Name:_____ Patient Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency contact name and phone # _____

Birth date:_____Social Security #:_____Drivers Lic#:_____

Patient Information:

Address: _____Address 2: _____

City, State, Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ Emergency contact name and phone #_____

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Pharmacy: _____Phone#_____How did you hear about our practice?_____

Primary Dental Insurance Information:

Name of policy holder:_____ Relationship to policy holder: ○Self ○Spouse ○Child ○ Other

Group #:_____ Subscriber ID: _____

Insured Social Security #: _____ Insured Birth date:_____

Employer Name:_____ Insurance Company Name:_____

Ins. Co.Address:_____ City, State, Zip:_____

Secondary Dental Insurance Information:

Name of policy holder: _____Relationship to policy holder: ○Self ○Spouse ○Child ○ Other

Group#:_____ Subscriber ID:_____

Insured Social Security #: _____Insured Birth date:_____

Employer Name:_____ Insurance Company Name:_____

Ins. Co. Address:_____City, State, Zip_____

Patient Signature/Parent or Guardian_____ Date_____

NANCY norling DDS

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Dental Insurance And You

The Patient Comes First!
You deserve the right care and the right compensation. Dr. Nancy Norling's dental treatment plans are tailored to provide you with the needed quality dental care. Dental insurance programs are designed to help with the financial coverage of your dental treatment.

Your Plan's Coverage
During the last decade, dental benefit plans became an integral part of health care planning. While these plans are made available to employees through companies, unions and associations, each may vary considerably. Your employer, the purchaser of the insurance plan, selects the range of benefits. The insurance plans may provide only limited coverage, or provide coverage of only specific services, such as preventive dental care.

You and your Insurance Plan
Typical criteria and terms espoused by insurance carriers include:

"Reasonable and customary fees"
"Yearly maximums"
"Pre-authorization"

Each of these criteria and terms varies by plan and insurance carrier. To ensure you receive maximum benefits, we recommend that you read your insurance booklet and become familiar with your specific plan requirements. Low reimbursement may be the result of coverage purchased for the insurance plan. If you feel the dental benefits are inadequate, discuss this matter with your employer so that alternatives can be investigated.

You and Your Insurance Claims
We can help. We will process all of your insurance claims expeditiously. All you need to do is fill out the top 'personal information' section of your insurance form and bring it to our office or bring you current insurance card with you.

Dental Treatment Payment Policy
We require payment at the time of treatment. Your insurance company will send payment directly to you in a timely manner.
Dr. Norling is a non participating provider for **Delta Dental** and **dental PDO's**. Many patients still choose to see Dr. Norling because they value the quality of care that they receive here.

Dr. Nancy Norling and her staff take pride in providing comfortable, quality dental care.

DIRECTIONS

NANCY**norling**DDS
1660 S. Hwy 100, Suite 122
Minneapolis, MN 55416
(952) 544-4129

Arriving from the EAST

Take I-94 West to I-394 West.
Exit on Highway 100 South to Cedar Lake Road and follow the curve to the right.
Our office building is the FIRST parking lot on right (across from Podany's Office Furniture) when you exit on Cedar Lake Road.

We are on the ground floor of 1660 Parkdale Plaza.

Arriving from the WEST

Take I-394 East to the Xenia/Park Place Blvd. exit.
Turn south (right) on Park Place Blvd. to Parkdale Drive.
Turn left on Parkdale Drive.
Our office building is the LAST parking lot on the left-hand side, before the entrance onto Highway 100 (across from Podany's Office Furniture).

We are on the ground floor of 1660 Parkdale Plaza.

Arriving from the SOUTH

Take Highway 100 North to the Cedar Lake Road exit (Cedar Lake Road runs parallel to Highway 100 for a short time).
Loop around the Fiat car dealership on the right-hand side and go under Highway 100.
At the stoplight, merge right onto Parkdale Drive.
Our office building is the LAST parking lot on the left-hand side, before the entrance onto Highway 100 (across from Podany's Office Furniture).

We are on the ground floor of 1660 Parkdale Plaza.

Arriving from the NORTH

Take I-694 West to Highway 100 South.
Exit on Cedar Lake Road and curve to the right.
Our office building is the FIRST parking lot on the right (across from Podany's Office Furniture) when exiting Cedar Lake Road.

We are on the ground floor of 1660 Parkdale Plaza.

TIME 1:39 PM Dr. Nancy Norling DATE 10/24/2013

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____