STAR DENTAL GROUP

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Dental Material Fact Sheet

On May 14, 2004, the Board updated the Dental Materials Fact Sheet.
Business & Professions Code section 1648.15, requires the following:

- *J* The dentist must provide this updated fact sheet to every new patient and to patients of record before performing dental restoration work. The dentist needs to provide the fact sheet to each patient only once.
- *J* The patient must sign an acknowledgment of receipt of the fact sheet and a copy of the acknowledgment must be placed in the patient's dental record.
- *J* If the Board updates the fact sheet, the updated fact sheet must be given to patients in this same way.
- *J* The dentist must also provide the fact sheet to the patient upon request.

This requirement shall not apply to any surgical, endodontic, periodontics, or orthodontic dental procedure in which dental restorative materials are not used. The dentist is responsible for copying this fact sheet for distribution. The updated fact sheet is currently available only in English. However, a Spanish version is expected soon.

I_____, acknowledge that I have received, from Ranjan Rajbanshi, DDS, Inc. a copy of the Dental Materials Fact Sheet.

Patient Signature _____ Date_____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____