Sean B. Abidin, DDS & Vanessa M. Cao, DDS, LLC

Notice of Privacy Practices

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 and will remain in effect until we replace it.

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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals

Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

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 of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:
Privacy Official Name: Vanessa Cao
Telephone: 614-882-9828
Fax: 614-839-0393
Address: 450 Alkyre Run Dr Ste 260, Westerville OH 43082
Email: info@abidincaodds.com

OUR PROMISE

We promise a gentle touch, a comfortable environment,
and a genuine smile.
We look forward to seeing you!

SEAN ABIDIN, DDS & VANESSA CAO, DDS
SMILE

PATIENT INFORMATION

Name	Date of Birth	SS#	
Address	City	State	Zip
Home Phone	Cell Phone	Email Address	
Check appropriate boxes: ❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Widowed ❑ Divorced ❑ Other:			
If Student, Name of School/College	City	State	❑ Full Time ❑ Part Time
Employer	City	State	Phone
Emergency Contact	Home Phone	Cell Phone	
Whom may we thank for referring you?			

DENTAL INSURANCE

Name of Insured	Relationship to Patient	SS#/Subscriber ID	
Date of Birth	Employer	Phone	
Insurance Carrier	Group Number	Phone	
Insurance Carrier Address	City	State	Zip

Is the patient covered by a Secondary Dental Plan? If YES, please complete the following:

Name of Insured	Relationship to Patient	SS#/Subscriber ID	
Date of Birth	Employer	Phone	
Insurance Carrier	Group Number	Phone	
Insurance Carrier Address	City	State	Zip

Dental Claim Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Drs. Abidin and Cao, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Drs. Abidin and Cao may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date

Privacy Practices Acknowledgment

I, _____ have been offered a copy of this office's Notice of Privacy Practices.
(Print Name)

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date

Although we primarily treat the area in and around the 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 honestly and completely.

SEAN ABIDIN, DDS & VANESSA CAO, DDS
SMILE

DENTAL HISTORY

Date of Last Dental Care	Date of Last Dental X-Rays	Former Dentist Name

Are you having or have you had any of the following:

- ❑ Pain in Teeth
- ❑ Sensitivity to Sweets
- ❑ Sensitivity when Biting
- ❑ Sensitivity to Hot
- ❑ Sensitivity to Cold
- ❑ Broken Teeth or Fillings
- ❑ Periodontal or Gum Disease
- ❑ Bleeding Gums
- ❑ Loose Teeth
- ❑ Bad Breath
- ❑ Food Collection Between Teeth
- ❑ Difficult/Surgical Extractions
- ❑ Frequent Headaches
- ❑ Grinding or Clenching
- ❑ Clicking or Jaw Popping
- ❑ Head, Neck, or Jaw Injuries
- ❑ Sores or Growths in or Around Mouth
- ❑ Orthodontic Treatment

Are you having or have you had any other concerns with your mouth and/or teeth? _____

Have you ever had instructions on the correct method of brushing your teeth? ❑ Yes ❑ No

Have you ever had instructions on the care of your gums? ❑ Yes ❑ No

How Do You Like Your Smile?

Rate your smile: ***HELP It!*** ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ***LOVE It!***

What, if anything, would you change about your smile? _____

_____

_____

Would you like more information on:

- ❑ Bleaching
- ❑ Implants
- ❑ Veneers/Cosmetic Dentistry
- ❑ Oral Cancer
- ❑ Other: _____

Name (print) _____

SEAN ABIDIN, DDS & VANESSA CAO, DDS

SMILE

Patient Name (print)_____

MEDICAL HISTORY

Physician's Name	Date of Last Visit	Phone

Please mark your response to indicate if you have/had any of the following diseases or problems. Please explain any marked conditions.

- ❑ AIDS/HIV
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina/Chest Pains
- ❑ Arthritis (rheumatoid/osteo)
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back problems
- ❑ Blood Disorder
- ❑ Blood Thinner
- ❑ Blood Transfusion
- ❑ Cancer/Chemo/Radiation
- ❑ Cold Sores/Fever Blisters
- ❑ Controlled Substance Use
- ❑ Diabetes (Type I or Type II)
- ❑ Eating Disorders
- ❑ Emphysema/COPD
- ❑ Epilepsy/Seizures
- ❑ Fainting/Dizziness
- ❑ Fibromyalgia
- ❑ GERD/heartburn
- ❑ Glaucoma
- ❑ Headaches/Migraines
- ❑ Heart Attack/Failure
- ❑ Heart Disease
- ❑ Heart Pacemaker
- ❑ Hepatitis (Type _____)
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ History of Bisphosphonates
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lupus
- ❑ Osteopenia/Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Respiratory Disease
- ❑ STDs
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Sleep Apnea
- ❑ Steroid Treatments
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tobacco Use (Type _____)
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Ulcers

Have you had any other serious illness or injury not listed above? If yes, please explain: _____

_____

_____

WOMEN

Are you pregnant or trying to get pregnant? ❑ Yes ❑ No
If yes, Due Date _____

Taking Oral Contraceptives? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No

ALLERGIES

- ❑ Acrylic
- ❑ Codeine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Metal
- ❑ NSAIDs
- ❑ Penicillin
- ❑ Clindamycin
- ❑ Seasonal
- ❑ Other: _____

List ALL Prescription Drugs you currently take:	List any Herbal Remedies, Vitamins, Supplements, or Over-the-Counter Drugs you take:

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 (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 _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____ _____
Signature of Privacy Officer

SEAN B. ABIDIN, DDS & VANESSA M. CAO, DDS

SMILE

Appointment and Payment Agreement

Payment at the time of services is expected. Prepayment is expected for appointments scheduled over an hour. For your convenience, we accept Care Credit, Credit or Debit cards. Our office will be happy to submit claims to your insurance company. ***A service charge of 1.5% per month will be added to all balances 60 days and older.*** The annual rate of the service charges is 18%. I understand that Sean B. Abidin, DDS & Vanessa M. Cao, DDS will make every effort to collect from my insurance company. I hereby authorize Sean B. Abidin, DDS & Vanessa M. Cao, DDS to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services covered by insurance for services rendered to me or my dependents.

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointment times at Sean B. Abidin, DDS & Vanessa M. Cao, DDS are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs related to staffing and supplies and in order to contain our costs and continue to provide you with affordable fine dentistry for your entire family, we maintain a No-Show/Cancellation Policy for all of our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or is unable to be kept, ***must be cancelled at least two business days in advance of the appointment.*** Cancellations must be made during normal business hours on workdays at least two full business days before the scheduled appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals. Patients will not be charged if cancellation is made two business days before their appointment. Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than two business days' notice, or no notice, a ***$50 charge will be billed.*** If a third no-show or same day cancellation occurs, we reserve the right to terminate the doctor-patient relationship as well as another $50 charge.

This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

The undersigned hereby authorizes the release or any information relating to all claims for benefits submitted on behalf of myself, spouse, or dependents including the assignment of benefits payable to Sean B. Abidin, DDS & Vanessa M. Cao, DDS. I further agree and acknowledge that my signature on this document authorizes my dentist to submit for myself, spouse, or dependents all insurance claims forms necessary for submission and that I will be bound by this signature as though the undersigned had personally signed the particular claim form.

Past due balances are subject to a late payment of 1.5% per month (18% annual).

Relationship to Patient: _____

Signature: _____Response Date: ____ /____ /_____

450 Alkyre Run Drive, Suite 260, Westerville, OH 43082 | 614.882.9828 PH | 614.839.0393 FX

SEAN ABIDIN, DDS & VANESSA CAO, DDS

SMILE

I, _____

First Name Last Name DOB

consent to have my/my dependent's dental work and/or photographs/videos posted within the dental practice of Sean B. Abidin, DDS & Vanessa M. Cao, DDS and on the office website, social media accounts, video or slide show presentations, print ads and all other marketing or advertising efforts that promote the dental practice.

_____ _____

Patient Name (printed) Patient Signature

_____ _____

Parent/Guardian Name (printed) Parent/Guardian Signature

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