The Dentists

301 Highway 71 W., Ste. 200
Bastrop, TX 78602-4111
P: 512.303.4545 or 512.321.4445
F: 512.321.7300
www.thedentists.us
email: office@thedentists.us

ABOUT YOU

Today's Date: _____

Patient's Name: _____

LAST FIRST MIDDLE

Title :_____(Mr/Ms/Mrs/etc.) Gender: ❒ Male ❒Female

Are you a new patient to this office? ❒ No ❒Yes

Family Status: ❒ Married ❒Widowed ❒Single ❒Minor ❒Separated ❒Divorced ❒Partnered

Date of birth: _____

Social Security #: _____

Driver's License #: _____

Address: _____

Mailing Address: _____

eMail: _____

Home Phone: (_____) _____

Work/School Phone: (_____) _____

Mobile Phone: (_____) _____

Daytime # to confirm appts.: (_____) _____

Patient Employer/School: (_____) _____

Pharmacy Name/Phone: (_____) _____

How did you hear of our practice?

❒ Building location
❒ Facebook
❒ Newspaper
❒ Google / Internet

Name of person, office or other source referring you to our practice:

_____

Person responsible for payment: If same as above, check box ❒ No ❒Yes
If "YES", skip to Dental Insurance.

Name: _____

LAST FIRST MIDDLE

Title:_____(Mr/Ms/Mrs/etc.) Relationship to patient:_____ Gender: ❒ Male ❒Female

Date of birth: _____

Social Security #: _____

Driver's License #: _____

Address: _____

Mailing Address: _____

eMail: _____

Home Phone: (_____) _____

Work/school Phone: (_____) _____

Mobile Phone: (_____) _____

Employer: _____

Dental Insurance:

Subscriber Name: _____

Date of birth: _____

Social Security #: _____

Name of Insurance Company:_____

Insurance Phone #: (_____) _____

Group plan #: _____

Subscriber ID #: _____

Employer name: _____

Relationship to insured: ❒ Self ❒Spouse ❒Child ❒Other _____

In the event of an emergency, whom should we contact?

_____Phone:_____

Name/address of your primary care physician:

_____Phone:_____

Chief dental complaint: _____

- Explain: _____

Are you in pain? ❒ No ❒Yes

- How long? _____

Are you now under the care of a physician? ❒ No ❒Yes

- If yes, what is the condition being treated?_____
- Name/Address of physician_____

Have you had any serious illness, operation or been hospitalized in the last 5 years? ❒ No ❒Yes

- If yes, what was the illness/problem?_____

Have you had any joint replacement surgery? ❒ No ❒Yes

Does your physician require you to take an **antibiotic pre-medication** prior to dental treatment for heart condition/artificial joints?

❒ Yes ❒ No ❒ Don't know

- If yes, what medication:_____

Do you have or have you had any of the following: – Please indicate ☼

❒ Are any of your teeth loose?
❒ Are you interested in oral sedation?
❒ Are you interested in nitrous oxide sedation?
❒ Blisters/sores in or around the mouth
❒ Broken/chipped tooth/teeth
❒ Discomfort, clicking, locking or popping jaw (please circle all that apply)
❒ Do you clench/grind your teeth (either consciously or during sleep)?
❒ Do you currently have any dental implants, dentures or partials? (please circle all that apply)
❒ Do your teeth experience sensitivity to cold/hot temperatures? (please circle all that apply)
❒ Have you had any trouble associated with any previous dental treatment?
  - If so, explain: _____
❒ Have you had orthodontics/braces?
❒ Is there a history of past difficulty with numbing areas in the mouth?
❒ Lost/broken fillings(s)
❒ Red, swollen or bleeding gums
❒ Is there anything you would like to change about your smile?
  - Expain:_____

MEDICAL INFORMATION – Please indicate ☼ If you are **allergic** or have you had a reaction to:

❒ Alcohol
❒ Aspirin
❒ Barbiturates, sedatives or sleeping pills
❒ Clindamyacin
❒ Dental anesthetics
❒ Latex
❒ Local anesthetics
❒ Milk
❒ Penicillin/Amoxicillin or other antibiotics
❒ Sulfa
❒ Tetracycline
❒ Tree nuts (e.g. walnuts, almonds, etc.)
❒ Codeine / Vicodin / Hydrocodone (please circle all that apply)

Others: _____

_____

Please **LIST ALL MEDICATIONS** you are currently taking and **WHY** you are taking them (includes over the counter (OTC) medications/vitamins):

❒**Check box if NO MEDICATIONS**

_____

_____

Please indicate ☼ if you have ever had any of the following diseases, medical conditions or procedures; explain where necessary.

- ❒ Artificial Bones / Joints / Implants / Heart Valves (please circle all that apply)
- ❒ Cancer / Tumors -
  - Where & when: _____
- ❒ Chemotherapy / Radiation -
  - When & for what: _____
- ❒ Cholesterol (high)
- ❒ Chest pains
- ❒ Congenital heart defect
- ❒ Heart Disease / Surgery / Pacemaker / Heart Attack (please circle all that apply)
  Date: _____
- ❒ Heart Murmur
- ❒ High / Low Blood Pressure (please circle one)
- ❒ Mitral Valve Prolapse
- ❒ Rheumatic / Scarlet Fever
- ❒ Stroke
  - Date: _____
- ❒ Asthma / Hay Fever/Difficulty Breathing / Respiratory Problems (please circle all that apply)
- ❒ COPD
- ❒ Emphysema
- ❒ Persistent cough or cough that produces blood (please circle all that apply)
- ❒ Sleep apnea
- ❒ Tuberculosis / TB
- ❒ Diabetes / Hypoglycemia (please circle one)
- ❒ Dry mouth
- ❒ Herpes / Fever blisters
- ❒ Jaw Problems / TMJ (please circle all that apply)
- ❒ Persistent swollen glands in neck
- ❒ Severe / Frequent headache / migraine (please circle all that apply)
- ❒ Sinus trouble
- ❒ Abnormal Bleeding / Hemophilia (please circle all that apply)
- ❒ Alcohol / Drug Abuse (please circle all that apply)
- ❒ Anemia/Blood disorder (please circle all that apply)
- ❒ Hepatitis: A B C (please circle all that apply)
- ❒ Jaundice or liver disease (please circle all that apply)
- ❒ Stomach ulcer or hyperacidity
- ❒ AIDS / HIV (please circle one)
- ❒ Alzheimer's / Dementia
- ❒ Anxiety / Anxiety attacks
- ❒ Epilepsy or other neurological disease (please circle all that apply)
- ❒ Fainting spells or seizures (please circle all that apply)
- ❒ Hearing Problems
- ❒ Kidney trouble
- ❒ Problems of the immune system
- ❒ Problems with mental health
- ❒ Thyroid Problems – Hyper / Hypo (please circle one)
- ❒ HPV (Human Papilloma Virus)
- ❒ Venereal / STD (Sexually transmitted disease)
- ❒ Vertigo / Dizziness

Do you use: Cigarettes ❒ Cigars ❒ Snuff ❒ Recreational drugs ❒

- If yes, explain

_____

_____

❒ **NO KNOWN MEDICAL CONDITIONS**

❒ Do you have any disease/ condition not previously listed that you think I should know about?

- If yes, explain

_____

_____

❒ Surgeries

- If yes, explain

_____

_____

FEMALE patients:

❒ Are you taking birth control?
❒ Are you pregnant?

- If yes, due date:_____
- OB name & phone #:_____

❒ Are you nursing?

Authorization

To the best of my knowledge, all the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect information has the potential of being hazardous to my health. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

As a condition of treatment by The Dentists, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

The Dentists is an out-of-network provider for most PPO insurance companies. PPO stands for Preferred Provider Organization. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to The Dentists practice to be applied directly to any outstanding balance on my account.

I understand that any fee estimate for dental care can only be extended for a period of 90 days from the date of the patient examination.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature_____

❒ Adult Patient ❒ Parent or Legal guardian

Witness_____

Date_____

THE DENTISTS - Office Use only:

Blood Pressure _____ *Pulse*_____

Taken by: _____ *Date*_____*Dr's Initials*_____

Comments on patient interview concerning medical history:

_____

_____

_____

Signature of Dentist:_____ Date: _____

APPOINTMENT CANCELLATION

&

NO-SHOW POLICY

Office hours are by appointment and we do value your time. It is our desire to provide you with the best possible care and attention that we are able to offer.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. Appointment times are reserved for you alone. As a courtesy to you, we will make every effort to confirm your reserved appointment. If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us 24 hours in advance to change or cancel the reserved time. This 24 hour notice allows us to offer that time to another patient. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

As of January 1, 2014, if you fail to show for an appointment or cancel with less than 24 hours notice, you will be charged $25 per hour of scheduled time.

Please note this missed appointment fee is not covered by any insurance plan and is your responsibility to pay.

This new policy has become a necessity and will affect all patients. It would be a disservice to you if we did not emphasize the importance of your own commitment to your dental care. With your compliance, we will be able to keep our schedule "on time", accommodate any emergencies and help patients on our waiting list.

By signing below, you acknowledge that you have read and understand the Appointment Cancellation and No-Show Policy for The Dentists as described above.

Thank you for your understanding and cooperation in this matter.

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

Patient/Guardian Signature: _____

Witness: _____

Date: _____

CONSENT TO RELAY INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to request that communications concerning your personal health/dental information (PHI) be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must give us an alternative address or other method of contacting you. **Some method of contact must be provided.**

We will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

This request supersedes any prior request for communication of information I may have made.

RESTRICTIONS ON COMMUNICATION METHODS

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below by **initialing** ways in which you want to receive communications:

_____No restrictions

_____Home phone Phone #:_____ May we leave messages? Y N

_____Work phone Phone #:_____ May we leave messages? Y N

_____Cell phone Phone #:_____ May we leave messages? Y N

_____eMail Address:_____

_____U.S. Mail Address:_____

EXTENDED AUTHORIZATION

Please list any person(s) you would like to have access to your billing, appointment or health/dental information, such as your spouse, caretaker or other family member:

Name Relationship Phone #

_____

_____

_____

Patient/Guardian Signature: _____

Witness: _____

Date: _____

FINANCIAL POLICY

The Dentists have a responsibility to provide quality dental services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality dental care, it is our hope you will take responsibility for your financial obligation to our practice. The following are general polices The Dentists have established for our patients, which we believe allow the flexibility some patients need. The Dentists encourage you to discuss your account and any payment difficulties with the Financial Coordinator. Early discussion of these issues in your treatment process will prevent most concerns or misunderstandings. Payment is required at the time of service unless prior financial arrangements have been made with this office.

1. **Insurance** – As a courtesy to our patients, we will file claims on all visits and procedures. When The Dentists file a claim on your behalf, it is with the understanding benefits will be assigned to The Dentists (that is, the insurance company will pay The Dentists directly.) Although we accept assignment of insurance checks, the patient is responsible for any amount not covered by insurance. Insurance companies do not guarantee payment on claims and reserve the right to make payments based on their estimation of usual and customary fees (UCR). Your dental insurance policy may base reimbursement on a fee schedule that is lower than our office fee. We do our very best to calculate the probable amounts on insurance reimbursements with the information provided by you and your carrier. All figures quoted are purely estimates and are not intended to be represented as final. Please remember, insurance coverage is a contract between the patient and the insurance company, not The Dentists. The ultimate responsibility for understanding your insurance benefits and for payment to your dentist rests with you.

2. **No Insurance –** Patients without insurance are expected to pay for all services rendered. The Dentists understand individual situations may make it difficult to meet these financial expectations and are available to discuss payment arrangements as needed.

3. **Past Due Accounts –** An interest charge of one percent (1%) per month will be charged to your account after 90 days. Patients, who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligations to The Dentists, may be turned over to collections. Patients, who have allowed their account to be turned over to collections, will be expected to satisfy their financial obligation to The Dentists, and to pay future services in advance, before being seen by the dentist.

4. **Returned Checks –** Your account will be charged a $35.00 fee for each returned check. In addition, you will be asked to bring cash to The Dentists office to cover the returned check and the returned check fee.

Patient Statement:

I have been informed of The Dentists financial policy and agree to its terms. I have been notified some insurance companies may deny payment for some procedures. If my insurance company does not pay for services rendered, I agree to be personally and fully responsible for payment of the remaining balance after insurance pays. I agree to pay for interest charges and any fee toward my account if financial arrangements are not kept.

Patient/Guardian Signature: _____

Witness: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer at The Dentists.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the

use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.
We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including to report adverse events, product defects or problems, biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

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

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Under State law, we are required to notify you of any unauthorized electronic disclosure of your protected health information. Uses and disclosures of your protected health information, whether electronic or printed, will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical

record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members, friends who may be involved in your care, or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our Privacy Officer.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule), or correctional facilities as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us, to the State Attorney General's office, or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at The Dentists for further information about the complaint process.

This notice was published and became effective on Thursday, June 02, 2016**.**

The Dentists
Karen Jackson
June 2, 2016

Patient/Guardian Signature: _____

Witness: _____

Date: ____