# Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Streamwood Smiles
"Dentistry to Smile About"

## Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If student, Name of School/College _____ City _____ State/ Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Parent _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card: ☐ Visa ☐ MasterCard ☐ I wish to discuss the office's payment policy

## Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How much is your deductible?_____ How much have you used?_____ Max annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How much is your deductible?_____ How much have you used?_____ Max annual benefit _____

# Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

How much is your deductible?_____ How much have you used?_____ Max annual benefit _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking _____ | ☐ | ☐ |
| 4. Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| 5. Have you ever taking Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | ☐ | ☐ |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | ☐ | ☐ |
| 7. Do you use tobacco? | ☐ | ☐ |
| 8. Do you use controlled substances? | ☐ | ☐ |
| 9. Do you have or have you had any of the following? | | |

| | Yes | No |
|---|---|---|
| 10. Are you wearing contact lenses? | ☐ | ☐ |
| 11. Are you allergic to or have you had any reactions to the following? | | |
| Local Anesthetics (e.g. Novocain) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list) | ☐ | ☐ |
| 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 months)? | ☐ | ☐ |
| 13. Women Only: | | |
| Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| Are you nursing? | ☐ | ☐ |
| Are you taking oral contraceptives? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| High Blood Pressure | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ |
| Fainting/Seizures | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Epilepsy/Convulsions | ☐ | ☐ |
| Leukemia | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| AIDS or HIV Infection | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| Cardiac Pacemaker | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Angina | ☐ | ☐ |
| Frequently Tired | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Arthritis | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Joint Replacement or Implant | ☐ | ☐ |
| Hepatitis/Jaundice | ☐ | ☐ |
| Sexually Transmitted Disease | ☐ | ☐ |
| Stomach Troubles/Ulcers | ☐ | ☐ |
| Chest Paints | ☐ | ☐ |
| Easily Winded | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Hay Fever/Allergies | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Radiation Therapy | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Recent Weight Loss | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Heart Trouble | ☐ | ☐ |
| Respiratory Problems | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ |
| Other _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

# Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed when brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems with your jaw? | | |
| Clicking | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 10. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 11. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 12. Have you had any orthodontic treatment? | ☐ | ☐ |
| 13. Do you wear dentures or partials? If yes, date of placement _____ | ☐ | ☐ |
| 14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 15. Do you like your smile? | ☐ | ☐ |

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all service rendered on my behalf or my dependent.

_____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

Signature _____ Date _____

103 S. Sutton Road
Streamwood, IL 60107
(630) 289-7111
www.streamwoodsmiles.com

Streamwood Smiles
"Dentistry to Smile About"

Dear Patient:

Thank you for choosing us as your dental health care provider. We are committed to keeping your dental health care costs down. In order to achieve this goal, please understand that payment of your bill is an essential part of our continuing cost containment efforts. The following is a statement of our financial arrangements prior to the beginning of treatment. The most frequently used plans include:

**Full Payment:** at the time of service. We accept CASH, CHECKS, DEBIT, and CREDIT CARDS.

**Divided Payment Plan:** partial payment at each visit. Estimated charges for treatment required divided by estimated visits required.

**Commercial Dental Financing Plan:** Our office has a contract with Care Credit. This company does require a credit application and offers several payment plans including no interest plans with no annual fees or prepayment penalties. Ask for a brochure.

**Regarding Insurance:** Our office will assist you with completing necessary forms, submitting a pretreatment/ claim on your behalf and review your dental benefits with you. We do require that the deductible, estimated co-payment, and services not covered be paid at the time of service. We will do our very best to accurately **ESTIMATE** what your insurance company will pay towards normally covered services. Please understand however, our calculations are strictly **ESTIMATES** and are no guarantee that your insurance company will reimburse us according to these estimates. Ultimately, your insurance is a contract between you and your insurance carrier. We are not a party to that contract. Any service that is not covered by your insurance company, for whatever reasons, is your financial responsibility.

**UCR (Usual and Customary Rates):** Our office is committed to providing treatment for our patients and we charge what is usual and customary for our area You are responsible for payment in full regardless of any insurance companies' determination of usual and customary rates.

**Delinquent Accounts:** Returned checks will be charged a $25 penalty. Payment for service rendered is not to be delayed due to accident/personal injury cases and/or martial disputes Balances older than 30 days will be subject to interest charged of 10% per month. Patient balances older than 60 days will be turned over to our collection agency. Any attorney or collection fees incurred due to a delinquency in payment will be charged to the patient.

**Missed appointments:** Unless canceled at least **2 Business days** in advance, our policy is to charge for missed appointments at the rate of $50 for every 30 minutes scheduled. Please help us to serve you better by keeping scheduled appointments

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read and understand the Financial Policy (above) and fully intend to stand by the financial arrangements made with Streamwood Smiles, for myself and other patients whose name I have provided to appear on my account.

x_____ _____

Signature - Patient or Responsible Party Date

# Patient Acknowledgment of Receipt of Notice of Privacy Practices

Streamwood Smiles
"Dentistry to Smile About"

PLEASE PRINT

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This offices' obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

## Patient or Personal Representative

Signature: _____ Date: _____/_____/_____

Name: _____
PLEASE PRINT

Relationship to Patient: _____

## For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) _____/_____/_____

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

Other _____

Attempt was made by: _____ Date: _____/_____/_____

# Patient Consent & Authorization for Release of Protected Health Information

Streamwood Smiles
"Dentistry to Smile About"

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone Number: _____

E-mail Address: _____

## Patient Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

**This authorization pertains to the following type of medical information about me:**

_____

_____

**I hereby authorize** _____
Name of individual(s) and/or organization providing this information

**to release the above-described information to** _____.
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for my purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

_____

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____.
Expiration date or event

If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

## Patient or Personal Representative

Signature: _____ Date: _____/_____/_____

Name: _____
PLEASE PRINT

Relationship to Patient: _____

## For Office Use Only

Received by: _____ Date: _____/_____/_____

# HIPAA 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.

## About This Notice

This notice 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 by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. 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 the time as well as any information we receive in the future. You can obtain any revised Notice of Privacy Practices by contacting our office.

## How We May Use and Disclose Your Protected Health Information

The following examples describe different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. We are permitted to use and disclose your protected health information for the following purposes. However, our office may never have reason to make some of these disclosures.

### *For Treatment*

We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may 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.

### *For Payment*

Your protected health information will be used, as needed, to obtain payment for your health care services. 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 your health plan to obtain approval for hospital admission.

### *For Health Care Operations*

We may use and disclose your protected health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this notice also may share information with each other for purposes of our joint health care operations.

### *Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services*

We may use and disclose your protected health information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

### *Fundraising Activities*

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 office and request that these fundraising materials not be sent to you.

### *Plan Sponsors*

If your coverage is through an employer sponsored group health plan, we may share protected health information with your plan sponsor.

### *Facility Directories*

Unless you object, we may use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation. 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. In this case, only the protected health information that is relevant to your health care will be disclosed.

### *Others Involved in Your Healthcare*

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.

### *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, as 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. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

### *Business Associates*

We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

### *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 your 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 to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

### *Legal Proceedings*

We may disclose your 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), in certain conditions in response to a subpoena, discovery request or other lawful process.

### *Law Enforcement*

We may also disclose your 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 the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

### *Coroners, Funeral Directors, and Organ Donation*

We may disclose your 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 your 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 your 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*

Your protected health information may be disclosed by us 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.

### *For Data Breach Notification Purposes*

We may use or disclose your protected health information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan, if applicable, through which you receive coverage.

### *Required Uses and Disclosures*

Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

## Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health in formation described above in this notice is prohibited or materially

limited by other laws that apply of the more stringent law.

## Your Rights Regarding Health Information About You

The 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 your protected health information that is contained in your designated file for as long as we maintain the protected health information. A "designated file" contains medical and billing records and any other records that your physician and the office uses for making decisions about you. 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 protected health information that is subject to law that prohibits access to protected health information. You must make a written request to inspect and copy your designated file. We may charge a reasonable fee for any copies.

Additionally, if we maintain an electronic health record of your designated file, you have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our office 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 healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or 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.

This office is not required to agree to a restriction unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you paid us out-of-pocket in full. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office 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 office.

**You have the right to restrict information given to your third party payer if you fully pay for the services out of your pocket.** If you pay in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the third party payer.

**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 office.

**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 your designated file for as 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 office if you have questions about amending your medical record. Your request must be in writing and provide the reasons for the requested amendment.

**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 healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

**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.

**You have the right to receive notice of a security breach.** We are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there

has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach: (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

## Complaints or Questions

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a written complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint. You may reach our office by calling: (_____)_____.
Telephone

If you have a question about this privacy notice, please contact our Privacy Officer at: (_____)_____.
Telephone

**Effective Date:** This notice is effective as of 9/23/2013.