

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST
 ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 E-MAIL _____ CELL PHONE _____ HOME PHONE _____
 SS#/SIN _____ BIRTHDATE _____
 CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
STATE/PROV.
 IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____
 PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
 BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____
 WHOM MAY WE THANK FOR REFERRING YOU? _____
 PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
 ADDRESS _____ HOME PHONE _____
 DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____
 EMPLOYER _____ WORK PHONE _____
 IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
 NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
 EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
 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 _____
 EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
 INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

Item 051-0797/27000 Patterson Office Supplies 800-637-1140

X
 SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR _____

PATIENT NUMBER _____

REGISTRATION

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____

DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

| | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. ARE YOU IN GOOD HEALTH..... | <input type="checkbox"/> | <input type="checkbox"/> | 12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR..... | <input type="checkbox"/> | <input type="checkbox"/> | 13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DATE OF YOUR LAST PHYSICAL EXAM: _____ | | | 14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____ | | | 15. DO YOU USE TOBACCO..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN..... | <input type="checkbox"/> | <input type="checkbox"/> | 16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS .. PLEASE EXPLAIN. _____ | <input type="checkbox"/> | <input type="checkbox"/> | 17. ARE YOU WEARING CONTACT LENSES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE ... IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____ | <input type="checkbox"/> | <input type="checkbox"/> | 18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. HAVE YOU HAD ANY ABNORMAL BLEEDING ... | <input type="checkbox"/> | <input type="checkbox"/> | 19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. DO YOU BRUISE EASILY..... | <input type="checkbox"/> | <input type="checkbox"/> | WOMEN ONLY: | | |
| 10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT .. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. HAVE YOU HAD A RECENT WEIGHT LOSS..... | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU NURSING..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | ARE YOU TAKING BIRTH CONTROL PILLS..... | <input type="checkbox"/> | <input type="checkbox"/> |

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO: | | | HIVES OR SKIN RASH..... | <input type="checkbox"/> | <input type="checkbox"/> |
| LOCAL ANESTHETICS LIKE NOVOCAINE..... | <input type="checkbox"/> | <input type="checkbox"/> | FAINING OR DIZZY SPELLS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| PENICILLIN OR OTHER ANTIBIOTICS..... | <input type="checkbox"/> | <input type="checkbox"/> | DIABETES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SULFA DRUGS..... | <input type="checkbox"/> | <input type="checkbox"/> | AIDS OR HIV INFECTION..... | <input type="checkbox"/> | <input type="checkbox"/> |
| BARBITURATES, SEDATIVES OR SLEEPING PILLS .. | <input type="checkbox"/> | <input type="checkbox"/> | THYROID PROBLEMS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ASPIRIN..... | <input type="checkbox"/> | <input type="checkbox"/> | ALLERGIES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| IODINE..... | <input type="checkbox"/> | <input type="checkbox"/> | ARTHRITIS OR RHEUMATISM..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ANY METALS (E.G., NICKEL, MERCURY, ETC.)..... | <input type="checkbox"/> | <input type="checkbox"/> | JOINT REPLACEMENT OR IMPLANT..... | <input type="checkbox"/> | <input type="checkbox"/> |
| LATEX / RUBBER..... | <input type="checkbox"/> | <input type="checkbox"/> | STOMACH ULCER..... | <input type="checkbox"/> | <input type="checkbox"/> |
| OTHER (PLEASE LIST) _____ | | | KIDNEY TROUBLE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING: | | | TUBERCULOSIS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER | <input type="checkbox"/> | <input type="checkbox"/> | PERSISTENT COUGH..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SCARLET FEVER..... | <input type="checkbox"/> | <input type="checkbox"/> | COUGH THAT PRODUCES BLOOD..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART DEFECT OR HEART MURMUR..... | <input type="checkbox"/> | <input type="checkbox"/> | CHEMOTHERAPY (CANCER, LEUKEMIA)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART TROUBLE, HEART ATTACK, OR ANGINA .. | <input type="checkbox"/> | <input type="checkbox"/> | SEXUALLY TRANSMITTED DISEASE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| CHEST PAIN..... | <input type="checkbox"/> | <input type="checkbox"/> | EPILEPSY OR SEIZURES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SHORTNESS OF BREATH..... | <input type="checkbox"/> | <input type="checkbox"/> | ANEMIA..... | <input type="checkbox"/> | <input type="checkbox"/> |
| PACEMAKER..... | <input type="checkbox"/> | <input type="checkbox"/> | GLAUCOMA..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART SURGERY..... | <input type="checkbox"/> | <input type="checkbox"/> | NERVOUSNESS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HIGH/LOW BLOOD PRESSURE..... | <input type="checkbox"/> | <input type="checkbox"/> | TONSILLITIS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| CONGENITAL HEART PROBLEM..... | <input type="checkbox"/> | <input type="checkbox"/> | TUMORS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SWELLING OF FEET, ANKLES, HANDS..... | <input type="checkbox"/> | <input type="checkbox"/> | MENTAL HEALTH CARE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HEPATITIS, JAUNDICE OR LIVER DISEASE..... | <input type="checkbox"/> | <input type="checkbox"/> | BACK PROBLEMS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| STROKE..... | <input type="checkbox"/> | <input type="checkbox"/> | CHEMICAL DEPENDENCY..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SINUS TROUBLE..... | <input type="checkbox"/> | <input type="checkbox"/> | MITRAL VALVE PROLAPSE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| LUNG OR BREATHING PROBLEMS..... | <input type="checkbox"/> | <input type="checkbox"/> | CORTISONE TREATMENT..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ASTHMA OR HAY FEVER..... | <input type="checkbox"/> | <input type="checkbox"/> | COLD SORES/FEVER BLISTERS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | HYPOGLYCEMIA..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | EATING DISORDERS..... | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT'S NUMBER _____

PATIENT'S DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING. | <input type="checkbox"/> | <input type="checkbox"/> | DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY | <input type="checkbox"/> | <input type="checkbox"/> |
| ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS. | <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH. | <input type="checkbox"/> | <input type="checkbox"/> |
| ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS. | <input type="checkbox"/> | <input type="checkbox"/> | DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH. | <input type="checkbox"/> | <input type="checkbox"/> |
| DO YOU FEEL PAIN TO ANY OF YOUR TEETH. | <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS). | <input type="checkbox"/> | <input type="checkbox"/> |
| DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH. | <input type="checkbox"/> | <input type="checkbox"/> | EVER WORN A BITE PLATE OR OTHER APPLIANCE. . | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES | <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST. | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? | | | HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS. | <input type="checkbox"/> | <input type="checkbox"/> |
| CLICKING. | <input type="checkbox"/> | <input type="checkbox"/> | DO YOU WEAR DENTURES OR PARTIALS. | <input type="checkbox"/> | <input type="checkbox"/> |
| PAIN (JOINT, EAR, SIDE OF FACE). | <input type="checkbox"/> | <input type="checkbox"/> | IF YES, DATE OF PLACEMENT _____ | | |
| DIFFICULTY IN OPENING OR CLOSING. | <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS. | <input type="checkbox"/> | <input type="checkbox"/> |
| DIFFICULTY IN CHEWING. | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| DO YOU HAVE FREQUENT HEADACHES. | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| DO YOU CLENCH OR GRIND YOUR TEETH. | <input type="checkbox"/> | <input type="checkbox"/> | | | |

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

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 PAYORS 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 PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

_____ SIGNATURE _____ DATE _____

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PATIENT'S NUMBER _____

Patient Acknowledgment of Receipt of Notice of Privacy Practices

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 office's 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: ____/____/____

This product is designed to provide accurate and authoritative information. However, it is not a substitute for legal advice and does not provide legal opinions on any specific facts or services. The information is provided with the understanding that any person or entity involved in creating, producing or distributing this product is not liable for any damages arising out of the use or inability to use this product. You are urged to consult an attorney concerning your particular situation and any specific questions or concerns you may have.
Important note: This is approved for use by the purchaser only. This form may not be shared publicly or with third parties.

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. 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

Other uses and disclosures of your protected health information 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 information described above in this notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements 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 that you may request. 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 notification requirements under this section only apply if the breach poses a significant risk for financial, reputational, or other harm to you. 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.

Not every impermissible use or disclosure of protected health information constitutes a reportable breach. The determination of whether an impermissible breach is reportable hinges on whether there is a significant risk of harm to you as a result of impermissible activity. For example, if your protected health information was inappropriately shared with a billing clerk and she understood her confidentiality obligations, you would not need to be notified of the breach. If we inadvertently disclosed that you received services at our facility, without more specifics, this also may not be a reportable breach because it may not have been a significant risk of financial or reputational harm. The key to determining potential harm is whether sufficient information was released that would allow identity theft or harm you because of the likelihood of sharing sensitive health data.

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 1/1/2011.



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