Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

SMILE MODERNE
by Dr. Chris

Patient Information

Patient Personal Information

First Name	*MI*	*Last Name*	*Date*
Preferred Name	*Date of birth*	*Marital Status*	
Gender	*Social Security #*	*Driver's License*	
Home/Cell #	*Work#*	*Email*	
Address:	*City*	*State*	*Zip Code*
Address 2:	*City*	*State*	*Zip Code*

Patient Communication Preferences

How would you like us to communicate with you for appointment reminders, promotions, etc.?

Email: ☐ Text message: ☐ Both: ☐

Responsible Party Personal Information

First Name	*MI*	*Last Name*	*Date*
Preferred Name	*Date of birth*	*Gender*	
Social Security #	*Driver's License*	*Email*	
Home/Cell #	*Work#*		
Address:	*City*	*State*	*Zip Code*
Address 2:	*City*	*State*	*Zip Code*

Responsible Party Communication Preferences

How would you like us to communicate with you for appointment reminders, promotions, etc.?

Email: ☐ Text message: ☐ Both: ☐

X

Patient Signature *Date*

X

Responsible Party Signature *Date*

SMILE MODERNE
by Dr. Chris

Patient Medical/Health 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 you will receive.

Thank you for answering the following questions.	YES	NO
Are you under a physician's care now?	☐	☐
Name of physician/clinic and phone number: _____		
Have you ever been hospitalized or have had a major operation?	☐	☐
_____		
Date of your last physical exam? _____		
Have you ever had a serious head or neck injury?	☐	☐
_____		
Are you taking any medications, pills, or drugs? (*If* YES*, please list*)	☐	☐
_____		
Do you take or have you taken Phen-Fen or Redux?	☐	☐
_____		
Have you ever taken Fosamax Boniva Actonel or any other medications containing bisphosphonates?	☐	☐
_____		
Are you on a special diet?	☐	☐
_____		
Do you use tobacco?	☐	☐
_____		
Do you bruise easily?	☐	☐

Women: Are you...

Pregnant or think you may be? _____ Nursing? _____ Taking oral contraceptives? _____

Are you allergic to any of the following?

Aspirin: ☐ Codeine: ☐ Metal: ☐ Sulfa Drugs: ☐ Penicillin: ☐ Acrylic: ☐ Latex: ☐ Local Anesthetics: ☐

Other? _____

Do you use controlled substances? _____

Do you have or have you had any of the following?

AIDS/HIV Positive: ☐	Irregular Heartbeat: ☐	Tuberculosis: ☐
Diabetes: ☐	Spina Bifida: ☐	Cancer: ☐
Hepatitis B or C: ☐	Artificial Joint: ☐	Hay Fever: ☐
Rheumatic Fever: ☐	Fainting Spells/Dizziness: ☐	Osteoporosis: ☐
Alzheimer's Disease: ☐	Kidney Problems: ☐	Tumors or Growths: ☐
Drug Addiction: ☐	Stomach/Intestinal Disease: ☐	Chemotherapy: ☐
Herpes: ☐	Asthma: ☐	Heart Attack/Failure: ☐
Anaphylaxis: ☐	Frequent Cough: ☐	Pain in Jaw Joints: ☐
Easily Winded: ☐	Leukemia: ☐	Ulcers: ☐
High Blood Pressure: ☐	Stroke: ☐	Chest Pains: ☐
Scarlet Fever: ☐	Blood Disease: ☐	Heart Murmur: ☐
Anemia: ☐	Frequent Diarrhea: ☐	Parathyroid Disease: ☐
Emphysema: ☐	Liver Disease: ☐	Venereal Disease: ☐
High Cholesterol: ☐	Swelling of Limbs: ☐	Cold Sores/Fever Blisters: ☐
Shingles: ☐	Blood Transfusion: ☐	Heart Pacemaker: ☐
Angina: ☐	Frequent Headaches: ☐	Psychiatric Care: ☐
Epilepsy or Seizures: ☐	Low Blood Pressure: ☐	Yellow Jaundice: ☐
Hives or Rash: ☐	Thyroid Disease: ☐	Congenital Heart Disorder: ☐
Sickle Cell Disease: ☐	Breathing Problems: ☐	Heart Trouble/Disease: ☐
Arthritis/Gout: ☐	Genital Herpes: ☐	Radiation Treatments: ☐
Excessive Bleeding: ☐	Lung Disease: ☐	Convulsions: ☐
Hypoglycemia: ☐	Tonsillitis: ☐	Hemophilia: ☐
Sinus Trouble: ☐	Bruise Easily: ☐	Recent Weight Loss: ☐
Artificial Heart Valve: ☐	Glaucoma: ☐	Cortisone Medicine: ☐
Excessive Thirst: ☐	Mitral Valve Prolapse: ☐	Hepatitis A: ☐
		Renal Dialysis: ☐

Have you ever had any serious illness not listed above? _____

Comments: _____

_____

X _____

Patient Signature *Date*

X _____

Responsible Party Signature *Date*

Relationship to the patient:

Self ☐

Guardian ☐

Parent ☐

SMILE MODERNE
by Dr. Chris

PATIENT CONSENT TO TREATMENT

NAME _____

Work to be done: I understand that I am having the following work done *(indicate all services being provided)*:

Drugs, Medications and Anesthesia:	☐	Hygiene and Periodontics (Perio therapy):	☐	Removal of teeth (Extractions):	☐
Fillings:	☐	Endodontic Treatment (Root Canals):	☐	Crown (caps) and Bridge:	☐
Dentures:	☐	X-Rays:	☐	Other:	☐

☐ 1. DRUGS, MEDICATIONS AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four [24] hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloryl hydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have Received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obsctruction of airway.

(Initials)_____

☐ 2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long-term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

PERIODONTICS – I understand that I may have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction. **(Initials)** _____

☐ 3. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advices me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time. Potential risks include, but are not limited to, the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery).

B. Injury to adjacent teeth, caps, or fillings.

C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporary temporomandibular joint difficulty.

D. Opening of the sinus requiring surgery.

E. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or, in remote instances, permanently. **(Initials)** _____

☐ 4. FILLINGS:

I have been advised of the need for composite (plastic) fillings to replace tooth structure lost to decay or fracture.

I understand that the composite restoration is an acceptable procedure according to the American Dental Association guidelines. The advantages and disadvantages of the materials have been explained to me. **(Initials)** _____

☐ 5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY):

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment.

I understand that treatment risks can include, but are not limited to, the following:

A. Post treatment discomfort.

B. Post treatment swelling of the gum area.

C. Infection.

D. Restricted jaw opening.

E. Breakage of root canal instruments during treatment.

F. Perforation of the root. **(Initials)** _____

☐ 6. CROWN AND BRIDGE (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges must be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(Initials) _____

☐ 7. DENTURES – COMPLETE OR PARTIAL:

The problems of wearing dentures have been explained to me including looseness, soreness, and possible breakage, and relining due to tissues change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction. **(Initials)** _____

☐ 8. X-RAYS – RADIOGRAPHIC IMAGES:

The Digital X-Rays or radiographs are an essential part of dental treatment. Imaging of your mouth and jaw is crucial for proper diagnosis and prevention. These images allow dentists to examine all parts of the mouth, teeth, jaw. Images we take in our office are digital. The actual exposure to radiation is little to none. But, as protocol, if you are pregnant or think you might be, or if you have any history of radiation to the head and neck please advise the person taking images. **(Initials)** _____

X

_____

Patient Signature *Date*

X

_____

Responsible Party Signature *Date*

Handle Me With Care

(In order to give you the best care, please check all that apply)

I gag easily. ☐

I feel out of control when I am lying down in the dental chair. ☐

I haven't been to the dentist in a long time, and I feel uncomfortable about what will be said about my teeth. ☐

I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them. ☐

Pain relief is a top priority to me. ☐

I don't like shots, or I have had a bad reaction to shots. ☐

Please tell me what I need to know about my mouth so I can make an informed decision. ☐

My teeth are very sensitive. ☐

I don't like the sound of that tool that makes the picking and scraping noise. ☐

I don't like cotton in my mouth. ☐

I hate the noise of the drill. ☐

I don't like the dental office smell. ☐

Please respect my time. I don't want to be left sitting in the reception area too long. ☐

I want to know the cost up front. No money surprises, please. ☐

I have difficulty listening and remembering what I hear while sitting in the dental chair. ☐

I have health problems and questions that we need to discuss. ☐

I don't like being left alone in the treatment room. ☐

I have problems with my back. ☐

I don't like the chair tipped back too far. ☐

I do not like to see dental instruments. ☐

I need to talk to you first, without sitting in the dental chair. ☐

Other concerns I would like to talk about... ☐

(Please Specify)

Patient Name

Name & Relationship to Patient if you are the Responsible Party

X

Patient Signature *Date*

X

Responsible Party Signature *Date*

SMILE MODERNE
by Dr. Chris

Photo or Video Release Consent Form

First Name *MI* *Last Name*

To Whom It May Concern:

I hereby give my permission to Smile Moderne to use the photograph or film of me described as: (i.e. name, Instagram handle, social media name,

I hereby waive all rights to this photograph and/or film, and give my permission for these images to be published or publicly distributed. I understand that my name, telephone number and address are for Smile Moderne's records only, and that my name and personal information will not be released to anyone else without my permission.

Do you consent? YES ☐ NO ☐

X

Signature *Date*

Relationship to the patient:

Self ☐

Guardian ☐

Parent ☐

SMILE MODERNE
by Dr. Chris

INSURANCE INFORMATION

PATIENT INFORMATION

First Name *MI* *Last Name*

SUBSCRIBER (INSURED) INFORMATION

First Name *MI* *Last Name* *Date of birth*

Social Security # *Driver's License*

Address: *City* *State* *Zip Code*

Address 2: *City* *State* *Zip Code*

EMPLOYER

	YES	NO
Is the plan through an employer?	☐	☐

Company Name & Address *City* *State* *Zip Code*

Address 2: *City* *State* *Zip Code*

PRIMARY INSURANCE

	PAY FOR MYSELF	DENTAL INSURANCE
Do you have dental insurance or will you be paying for yourself?	☐	☐

Insurance Name & Type: _____

(i.e. Delta Dental PPO, Aetna DPPO...etc.)

Subscriber ID#: _____ Group #: _____ Medicaid ID #: _____

SECONDARY INSURANCE

	YES	NO
Do you have secondary dental insurance?	☐	☐

Insurance Name & Type: _____

(i.e. Delta Dental PPO, Aetna DPPO...etc.)

Subscriber ID#: _____ Group #: _____ Medicaid ID #: _____

X

Patient Signature *Date*

X

Responsible Party Signature *Date*

Smile Moderne Financial Policy

Welcome! Thank you for selecting Dr. Auyong as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy

FINANCIAL AGREEMENT:

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, American Express, MasterCard and/or Discover. We also offer CARECREDIT, which is a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance charge of 18% per annum after 90 days.

OPTIONAL PAYMENT TERMS:

1. Term Loan: By arrangements with CARECREDIT, we can offer patients upon approval, an interest delayed loan (up to 12 months) with no down payment, no annual fee and no prepayment penalty. Ask for an application.

APPOINTMENTS:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 48-hour notice for any cancelled appointment. After missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours. We charge a $50.00 cancellation fee for any appointments that is cancelled after our 48-hour policy.

INSURANCE INFORMATION:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this, we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January- December).

Dr. Christopher Auyong will diagnose treatment based on your dental health not your insurance coverage. You must realize that:

Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay. However, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling. If your insurance has not paid within 90 days of services rendered, you will need to make a full payment to this office. You will be reimbursed only when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. The insured has a better ability to deal with the insurance company and the employer responsible for the policy. Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy should be signed by the patient and/or all responsible parties.

X

Patient Signature *Date*

X

Responsible Party Signature *Date*

Smile Moderne 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.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Smile Moderne ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Smile Moderne's Privacy Official at:

Christopher Auyong DDS
25500 Rancho Niguel Rd. Suite 200
Laguna Niguel, CA 92677
(949) 554-1563
(949) 554-1565
Drchris@smilemoderne.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. 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 that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on JUNE, 2013.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "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 a business associate to assist us in maintaining our practice management software. 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.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

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 of disclosure indicated in the authorization. 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, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (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 health information.

The breach notification 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.

VIII. 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 HIPAA 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.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is June,2013.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

X

Patient Signature	*Date*

X

Responsible Party Signature	*Date*