PATIENT REGISTRATION – Please complete the following information

The Healthy Smile Center — General Dentistry

Date: _____

Last Name First M.I.

Nickname/ I prefer to be called by

Street Address

City State Zip Code

Home Phone No. Cell Phone No.

E-Mail Address (for patients age 18 and older)

Birthdate _____ Male _____ Female _____

Married ____ Single ____ Divorced ____ Widowed ____

SSN _____ - _____ - _____

Employer Work Phone #

Occupation _____

If necessary, may we contact you at work? Yes No

ACCOUNT INFORMATION

Name of Guarantor:

Social Security No.:

Street Address:

City/ State/ Zip:

Relationship to patient:

PRIMARY DENTAL INSURANCE

Employer:

Insurance Company:

Group No.:

Subscriber Name:

Address:

Phone No.:

DOB: SS#:

Relationship to patient:

SECONDARY DENTAL INSURANCE

Employer:

Insurance Company:

Group No.:

Subscriber Name:

Address:

Phone No.:

DOB: SS#

Relationship to patient:

HOW DID YOU HEAR ABOUT US

Who referred you to our office?

EMERGENCY CONTACT INFORMATION

Name:

Address:

Phone #: Cell #:

CONSENT FOR TREATMENT & INSURANCE CLAIM SIGNATURE/ FINANCIAL RESPONSIBILITY

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (*name of patient*) _____ dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.
4. I understand that I can ask for a complete recital of any possible complications.
5. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
6. We assume that any person delivering a minor for treatment is considered by you to be an authorized representative and **a legal adult** who can consent to treatment and receive private health information for your child in your absence. We request the representative be on premises during treatment time. The Healthy Smile Center prefers to discuss any changes to treatment with a parent or authorized representative before proceeding.
7. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with all claims.
8. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to The Healthy Smile Center.

If a parent or a legal adult is not on premises, treatment will proceed *only* as scheduled. All appointments for minors must be scheduled by a parent or authorized representative who is a legal adult and can authorize treatment.

Parent/ Responsible Party's Signature _____ **Date** _____ **Relationship to patient** _____ **Witness** _____

☐ **If new patient, ID verified by** _____

I. MEDICAL HISTORY

The Healthy Smile Center — General Dentistry

Patient Name:_____

Welcome!

So that we may provide you with the best possible care,
please complete this medical history form.

All information is completely confidential.

Which of the following do you have presently or have had in the past. ***Please Indicate Y (yes) or N (no) for each question:***

Y	N	Conditions
		Artificial Heart Valve
		Artificial Joints
		Osteoporosis
		Bone Density Drug History
		Bleeding problems
		Blood Thinners
		Congenital Heart Defect
		Diabetes
		Epi Sensitive
		Foramen Ovale
		Heart Attack _____
		Heart Pacemaker
		Heart Transplant
		High blood pressure
		Infective endocarditis
		Latex sensitive
		Epilepsy or Seizures
		COPD
		_____
		Asthma
		Blood Transfusion
		Bruise easily

Y	N	Conditions
		Cortisone Medicine
		Depression
		Dialysis/Chemotherapy Shunt
		Emphysema
		Fainting or Dizzy spells
		HIV positive/ AIDS
		Heart Disease
		Heart Surgery _____
		Hemophilia
		Hepatitis A
		Hepatitis B
		Hepatitis C
		Kidney problems
		Liver disease
		Mitral Valve prolapse
		Nervous/ Anxious
		Neurological disorders
		OSA (obstructive sleep apnea)
		Psychological care
		Radiation/ Chemotherapy
		Reflux
		Sickle Cell disease

Y	N	Conditions
		Stroke _____
		Swollen ankles
		Thyroid problems
		Tuberculosis
		Tumors
		Ulcers

Y	N	Allergies
		Aspirin
		Codeine
		Dental Anesthetics
		Erythromycin
		Jewelry
		Latex
		Metals
		Penicillin
		Tetracycline

Other _____
_____
_____

Y	N	If female please answer the following
		Are you taking birth control pills
		Are you pregnant
		Are you nursing

If yes, # of weeks _____

Y	N	
		Do you have any disease, condition or problem not listed above?
		Have you gained or lost more than 10 pounds in the past year?
		Have you been under the care of a medical doctor during the past 2 years?

If yes, please list. _____

If yes, for what? _____

Physician's name _____ Phone _____

Address _____ City/State _____/_____

I understand the above information is essential to provide me with dental care in a safe and efficient manner. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any changes in my health or medication at each visit. I have answered all questions to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____

MEDICAL HISTORY REVIEW

DOCTOR SIGNATURE: _____ **Date** _____

II. DENTAL HISTORY

The Healthy Smile Center — General Dentistry

Patient Name:_____

Welcome!

So that we may provide you with the best possible care,
please complete this dental history form.

All information is completely confidential.

What is the reason for your visit today?_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit?_____

Previous Dentist's Name _____ **Telephone/Address** _____

How often do you have dental exams? _____ **How often do you brush your teeth?** _____ **How often do you floss?** _____

What other dental aids do you use? **(Electric toothbrush, toothpick, etc.)** _____

Do you have any dental problems now? **Yes** **No** **If yes, please describe:** _____

Is there anything about having dental treatment that you would like us to know? **Yes** **No**

If yes, please explain_____

Please tell us what prosthetics you currently have (if applicable), circle all that apply

Full upper denture **Full lower denture** **Upper partial denture** **Lower partial denture** **No denture/partial** **Implants**

Are you having any problems with your denture(s)/ partial(s) _____

What is the approximate age of your existing denture(s)/ partial(s)? _____ **Do you like the way your denture(s)/ partial(s) look?** **Yes** **No**

If you are here today to discuss mini dental implants, what is it you hope to accomplish? _____

Are any of your teeth sensitive to:		
Hot or cold?	Y	N
Sweets?	Y	N
Biting or chewing?	Y	N
Have you noticed any mouth odors or bad taste?	Y	N
Do you frequently get cold sores, Blisters, or any other oral lesions?	Y	N

Have you ever had the following:		
Orthodontic treatment?	Y	N
Oral surgery?	Y	N
Periodontal treatment?	Y	N
Your teeth ground or bite adjusted?		N
A bite plate or mouth guard?	Y	N
A serious injury to the mouth or head?	Y	N
If yes, please describe:		

Tell us about your teeth and gums:		
Have your parents experienced gum disease or tooth loss?	Y	N
Have you noticed any loose teeth or change in your bite?	Y	N
Do your gums bleed or hurt?	Y	N
Does food tend to become caught in between your teeth?	Y	N
If yes, where?		

Have you experienced the following:		
Clicking or popping of the jaw?	Y	N
Pain? (joint, ear, side of face)	Y	N
Difficulty in opening or closing the mouth?	Y	N
Difficulty in chewing on either side of the mouth?	Y	N
Headaches, neckaches or shoulder aches?	Y	N
Sore muscles (neck, shoulders)?	Y	N

Do you:		
Clench or grind your teeth while awake or asleep?	Y	N
Bite your lips or cheeks regularly?	Y	N
Hold foreign objects with your teeth?	Y	N
If yes, circle all that apply (pencils/pens, pipe, pins, nails, fingernails)		
Mouth breathe while awake or asleep?	Y	N
Have tired jaws, especially in the morning?	Y	N
Smoke/chew tobacco?	Y	N

Are you satisfied with your teeth's appearance?		
Would you like to keep your teeth all of your life?	Y	N
Do you feel nervous about having dental treatment?	Y	N
If so, what is your biggest concern?		
Are you satisfied with your teeth's appearance?	Y	N
Have you ever had an upsetting dental experience?	Y	N
If yes, please describe:		

☐ Dr.'s initials when page completed and reviewed

III. The Healthy Smile Center and Your Insurance Plan & How They Work Together

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept most private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services.) Although we maintain computerized histories of payment by a given company, they do change, therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is, **ONLY AN ESTIMATE**. If you would like a closer estimate of your insurance benefit we will be happy to file a *pre-treatment estimate* with your insurance company prior to treatment. This does delay treatment but will give you a closer estimate of your out of pocket costs. ****Please inform us if you would like us to submit a pre-treatment estimate.****

I THOUGHT I PAID MY PORTION, BUT I HAVE A BALANCE. WHY?

We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. **Occasionally, exclusions may apply to your insurance plan of which we have not been informed**. Insurance companies do not notify us of changes to your benefits.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, The Healthy Smile Center reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize the insurance you have as a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

The Healthy Smile Center does request payment in full for your *estimated* portion at the time of service. We accept cash, checks, MasterCard, VISA, Discover and American Express. If you are in need of an extended finance option, we also work with CareCredit who offers, upon approval, up to twelve months deferred interest. Extended payment plans are also available, if you have questions or require additional information, please ask a Patient Service Staff member.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted.
If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

IV. Authorization and Consent To Send Unencrypted Patient Information via Secure Email

I authorize The Healthy Smile Center to transmit patient information relating to my treatment, health or payment by email or other electronic means, to me or someone I designate or to other health care providers, health plans and others involved in my treatment, payment for my treatment or The Healthy Smile Center's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment and payment records.

I understand that:

- The Healthy Smile Center does not email such sensitive personal information such as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse or positive HIV status unless the patient insists.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, The Healthy Smile Center may use other ways to send my information such as U.S. Mail or may ask me to send my information to third parties myself.
- I do not have to sign this form.
- There is a minimal risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- I can tell you in writing to stop emailing my patient information at any time, and if I do so, this will not affect emails that The Healthy Smile Center already sent before receiving my written instructions to stop.

By signing below I am confirming that I have read and understand sections I. and II.

Signature _____ **Date** _____

V. TMJ Health Questionnaire

Pain Symptoms	Y	N		Y	N
Do you get tension headaches?			Do you get headaches in right or left temple area?		
Do you ever get "migraine headaches"?			Do you get headaches in the back of your head?		
Do you have trouble sleeping soundly?			Does your jaw ache when you open wide?		
Have your teeth been sore upon awakening			Have you ever had chronic shoulder or back pain?		
Are your jaws tired when you awaken from sleep?			Have your wisdom teeth been extracted?		
Do you frequently have neckaches or stiff neck muscles?			Do you grind your teeth when asleep?		
When are your symptoms worse?					
Does anything make you feel better?					
How often do you take medicine for relief of pain? A) Never B) Weekly to Monthly C) Weekly D) Daily					

Jaw Joint Symptoms	Y	N	Jaw Joint Symptoms	Y	N
Does your jaw feel tired after a big meal?			Do you feel or hear a "clicking", or "popping" or "cracking" noise from either jaw point?		
Are there any foods you avoid eating?			Has your jaw ever locked when you were unable to open or close?		
Do you ever get dizzy?			Do you ever feel nauseated (sick)?		
Do you have difficulty opening wide or yawning?			Is there a family history of jaw joint (TMJ) problems or headaches?		
Have you ever had pain in either joint?					

Ear and Eye Symptoms	Y	N	Ear and Eye Symptoms	Y	N
Do you have itchiness or stuffiness in either ear?			Do you have any pain in your ears?		
Do you suffer from any loss of hearing?			Do you hear ringing, buzzing, or hissing sounds in either ear?		
Do you get pain in, around or behind either eye?			Do you hear grating noises in your ears?		
Are there any times when your eyesight blurs?			Do you wear glasses or contacts?		

Breathing	Y	N	Trauma or Accidents	Y	N
Do you have any allergies?			Have you ever had a severe blow to the head or jaw?		
Do you have a sinus problem?			Any whiplash neck injuries?		
Is your nose stuffed when you don't have a cold?			Have you ever been involved in any serious accidents? (i.e.: car accident		
Do you snore at night?			Details:		

VI. The Epworth Sleepiness Scale

The Epworth Sleepiness Scale (ESS) was developed and validated by Dr. Murray Johns of Melbourne, Australia. It is a simple, self-administered questionnaire–widely used by sleep professionals in quantifying the level of daytime sleepiness. (Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14 (6):540-5)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 'just tired'? This refers to your usual way of life at present and in the recent past. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation.

0 = would **never** doze ● 1 = **slight** chance of dozing ● 2 = **moderate** chance of dozing ● 3 = **high** chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching television	_____
Sitting, inactive in a public place (e.g. theatre, meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

☐ Dr.'s initials when page completed and reviewed

_____
PATIENT INITIALS

VII. New Patient Entrance Checklist

- ☐ For the convenience of our patients we have extended office hours.
  The office hours are: 8am to 7pm M/T/W/TH and 8am to 1pm Fridays. Occasionally, our office will open at 7am on select Wednesday and Thursdays. Additionally, our office may close on select Fridays.

- ☐ We will make every effort to schedule your hygiene appointments on a day that your doctor is here. If your Doctor isn't here that day, you are encouraged to take the opportunity to meet one of the other Doctors who can provide you with your exam or you have the option to reschedule to a day when your Doctor is here. All work diagnosed from the exam can be scheduled with your Doctor. **If after two weeks we have been unable to contact you regarding your x-ray results, please contact our office.**

- ☐ So that you do not have to sign an insurance claim form, we ask that you sign the back of your Patient Registration form. We submit our dental claims electronically and this form is in lieu of a signature on the actual claims we submit each time treatment is done.

- ☐ Insurance Letter Review – We will make every effort to help you resolve any insurance problems that may arise, if your insurance does not pay within 90 days the balance becomes the responsibility of the patient or the guarantor of the account and we will reimburse you if payment is made from the insurance company to us if your account is at a zero balance.

- ☐ So that we can estimate your co-payments that are due at the time of service, we keep track of the last payment received from your insurance plan for that code. **Occasionally exclusions apply to an individual patient's plan that we have not been informed of. We make every effort to provide patients with accurate co-payments, however, *it is only an estimate*.** *Please inform us if you would like a pre-treatment estimate submitted, this will delay your needed treatment by 4 to 6 weeks.* We accept many different credit cards and offer various discounts for treatment paid for in advance. If you are in need of an extended finance option, we also offer payment plans upon approval, which offers up to twelve months "Same as Cash" or an extended payment plan that offers smaller payments for a longer period of time. Just ask a member of the Patient Service Staff for more details if in the future these options would be of interest to you.

- ☐ For your convenience we try to confirm your appointments with a courtesy call. If you find that you are unable to attend that appointment, we ask that you call us 24 – 48 hours in advance. Because we customize the appointment to meet your individual needs, a broken appointment without this advanced notice could result in a fee to your account.

- ☐ Please feel free to contact us if you do not understand your bill. You will receive a statement after insurance has paid or on a monthly basis if there is a balance. So that your account does not accrue a higher balance, we ask that your account be paid in full (excluding insurance balances under 90 days) before scheduling future visits.

I have read, understand and accept the terms of the above outlined policies for The Healthy Smile Center.

_____
PATIENT INITIALS

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 22, 2015 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY SEND HEALTH INFORMATION ABOUT YOU

Your protected health information (PHI) includes information relating to your mental or physical health and to the health care provided to you, including materials like your dental records, dental x-rays and payment records. Some documents containing PHI may include sensitive information. Sometimes our dental practice needs to send PHI to the patient or to someone else such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice does not encrypt email or other electronic forms of communication. There is a risk that unencrypted information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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

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

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

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

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

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

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:
- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

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

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

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

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

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

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

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

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

Other Uses and Disclosures of PHI

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

Your Health Information Rights

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

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

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

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

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

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

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the ad dress to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Debra A. Balogh-Crombie D.D.S. **Telephone**: 440-992-2700 **Fax**: 440-964-0542 **Address**: 2010 W. 19th St., Ashtabula, OH 44004 **Email**: **thehealthysmilecenter@windstream.net**

VIII. Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I acknowledge I have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because of the following reason:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

IX. Prescription (Rx) & Over the Counter (OTC) Medication Log

The Healthy Smile Center — General Dentistry

Patient Name:_____

☐ No Hx. of bisphosphonates (BPS)/ Date _____ ☐ BPS use/ Date & Hx. _____ / _____

PLEASE PRINT							OFFICE USE ONLY		
							DISCONTINUED DRUGS		
DRUG NAME (Rx and OTC)	DOSAGE	FREQUENCY	FOR WHAT CONDITION IS THIS DRUG TAKEN?	PATIENT INITIALS	STAFF INITIALS	DATE DRUG LOGGED IN	PATIENT INITIALS	STAFF INITIALS	DATE DRUG LOGGED OUT
EXAMPLE: Wellbutrin	150mg	1x per day	depression	JMD		1/13/89			
1.									
2.									
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14.									

Prescription (Rx) & Over the Counter (OTC) Medication Log

The Healthy Smile Center General Dentistry

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