Pelham Links Family and Cosmetic Dentistry, P.A.

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Welcome to our Family Practice. We consider this a privilege and honor to allow us to care for your dental needs. Our staff is committed to serve you in the most professional manner. To insure that your health is safe guarded to the utmost, we ask that you complete the following questionnaire as accurately as possible. Rest assured this information is held in strict medical confidence.

PATIENT INFORMATION

Date ____/____/____

S.S. #	- -
Gender	**Male** **Female**
Birth Date	

Name _____ (Last) (First) (Middle)

Street Address _____

City _____ ST _____ Zip _____

E-mail Address _____ Home Phone _____ **Cell Phone or Pager** _____

Employer _____ Work Phone _____

Driver's License# _____ If patient is a minor, give parent's or guardian's name _____

Emergency contact person (other than spouse): _____ Relationship _____

Address: _____ Phone number _____

Whom may we thank for referring you to our office? _____

SPOUSE INFORMATION

Spouse's Name _____ (Last) (First) (Middle)

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ D.O.B. _____

Social Security # _____ Employer _____

RESPONSIBLE PARTY INFORMATION

Name _____ (Last) (First) (Middle) _____ (Marital Status)

Social Security # _____ D.O.B. _____ Relationship to Patient _____

Employer _____ Work Phone _____ Occupation _____ No. Years Employed ____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance	Secondary Dental Insurance
Insured Name _____	Insured Name _____
Date of Birth _____	Date of Birth _____
Insured Social Security # _____	Insured Social Security # _____
Insured Employer _____	Insured Employer _____
Relationship to patient _____	Relationship to patient _____

If there were a safe and inexpensive way to brighten your smile, would you be interested? YES NO

(PLEASE COMPLETE REVERSE SIDE)

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.

DENTAL HISTORY

Do you have a specific dental problem? Describe _____

Do you have dental examinations on a routine basis? Last visit? _____

Do you ever have clicking or discomfort in the jaw joints (TMJ)? Discuss _____

Name of previous dentist (optional) _____

MEDICAL HISTORY

Are you under a physician's care now? Doctor's name? Yes No _____

Have you ever been hospitalized or had a major operation? Yes No _____

Have you ever had a serious head or neck injury? Yes No _____

Are you taking any medications, pills, or drugs? Yes No

List Medications: _____

Are you on a special diet? Yes No Do you use any tobacco products? Yes No

Do you use controlled substances? Yes No

Do you take or have you ever taken the following drugs either orally or IV? *(Please Circle)*

Bisphosphonate Therapy:

Oral Medications	IV Medications
Alendronate (Fosamax)	**Editronate (Didrone)**
Ibandronate (Boniva)	**Pamidronatē (Aredia)**
Risedronate (Actonel)	**Zonledronic Acid (Zometa)**
Tiludronate (Skelid)	**Reclast**
Etidronate (Didrone)	

WOMEN Are you: ☐ **Pregnant/Trying to get pregnant?** ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? Do you have any allergies? Please list: _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Please CIRCLE if you have had any of the following:

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

Have you ever had any serious illness not listed above? Yes No N/A

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient, Parent or Guardian Date

Dentist's Comments:

Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date
Dentist's Signature	Date	Dentist's Signature	Date	Dentist's Signature	Date

Pelham*links*
Family and Cosmetic Dentistry
Our Doctors Create Beautiful Smiles

MEDICAL INFORMATION RELEASE FORM

NAME: _____ DOB: _____

Release of Information

□ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

□ Spouse: _____

□ Children: _____

□ Other: _____

□ Information is **not** to be released to anyone.

This **RELEASE OF INFORMATION will remain effective until terminated by me in writing**

The best way to contact or to leave messages for me is:

□ My home phone □ My work phone

□ My cell phone □ Other _____

If unable to reach me:

□ You may leave a detailed message

□ Please leave a message asking me to return your call

□ Other _____

Signed: _____ Date: _____

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805 W. Georgia Road • Simpsonville, SC 29680 • Office: (864) 757-1500 • Fax: (864) 757-1510
www.pelhamlinks.com

Pelham Links Family and Cosmetic Dentistry

Financial Policy

We at Pelham Links Family and Cosmetic Dentistry, P.A. are pleased you chose us to facilitate and care for your dental health needs. As in the past, we require that payments are made at the time of service. For those patients who have financial assistance from insurance, the co-payment is due at this time.

We accept MasterCard, Visa, American Express, Discover and Care Credit, as well as cash or personal checks. In a few instances, we are able to offer financial arrangements. We'll be happy to discuss these options with you if the situation applies.

Emergency Patients: For emergency patients, who are not a patient of record, we will file any insurance claims, as long as we can verify your benefits. If we are unable to verify these benefits, we will require payment in full.

Minors with two separated or divorced parents: When two parents are each responsible for one half of the cost of the children's dental care, the parent who brings in the child is responsible for paying the co-payment or full fee. They will also be responsible for collecting payment from the other parent.

NSF/Returned Checks: There is a $25.00 fee for processing a returned or NSF check. We reserve the right to reject check payments once a returned or NSF check occurs.

Short Notice Cancellations, Broken Appointments or Disconnected Numbers: Each appointment is a reserved time for you and only you. Each time you do not keep your appointment, other patients who do keep their appointments are penalized. Although we do not like to charge for broken appointments, no-show or short notice cancellations, we do reserve the right to refuse to schedule more appointments unless paid in full before service is commenced and/or charge a $25.00 fee. Also, if the phone number we have on file for you is disconnected, leaving us no alternative number to reach you by, we will cancel your appointment and reserve the right to not reappoint your appointment.

Deposits: Many times a deposit is required. This varies by length of appointment or complexity of procedure you require, we will notify you if a deposit is needed.

I, _____, have read and understand the financial policies of Pelham Links Family and Cosmetic Dentistry, P.A. I understand that I am ultimately responsible for all fees incurred for my dental treatment. (This agreement will apply to any and all accounts in which I am the responsible party. A copy will be placed in those charts as well as my own).

I also understand that since insurance plans are payment assistance plans, they are not designed to cover the entire cost of treatment. I understand that my dental insurance carrier may pay less that the bill for services. If the insurance claim(s) is not paid in 60 days, the balance will become my responsibility. By signing this form, I have authorized assignment benefits directly to the practice.

Most insurance companies are now "deciding" which type of restorative filling the patient should receive, regardless of the clinical indication. While this office does everything possible to maximize the insurance benefits, I am aware that Pelham Links Family and Cosmetic Dentistry, P.A. will diagnose the type of restorative filling that is needed due to their Standard of Care, not what the insurance company decides. This will mean for some patients, based on the insurance company's benefit plan, composite resin (tooth colored) fillings on posterior teeth will only be reimbursed at the amalgram (metal) filling rate, with the remainder of the fee due from the patient.

I am also aware that the office reserves the right to charge 1.5% interest for any balance over 90 days old, as well as any and all additional charges that might occur if the account is turned over for collection and/or attorney services are required.

Signed _____ Date_____

(*This notice replaces and supersedes all previous financial policy notices from Pelham Links Family and Cosmetic Dentistry, P.A. until otherwise notified. Effective March 26, 2007*)

Pelham Links Family & Cosmetic Dentistry, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: (____) _____-_____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time.

Signature

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent to your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature _____ Date: _____

INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART

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: ____/____/____

HIPAA Notice of Privacy Practices

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

About This Notice

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

We are required by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time as well as any information we receive in the future. You can obtain any revised Notice of Privacy Practices by contacting our office.

How We May Use and Disclose Your Protected Health Information

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

For Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

For Payment

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

For Health Care Operations

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

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

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

Fundraising Activities

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our office and request that these fundraising materials not be sent to you.

Plan Sponsors

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

Facility Directories

Unless you object, we may use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people

that ask for you by name. Members of the clergy will be told your religious affiliation. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

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

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

Public Health
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

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

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

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

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

Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

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

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

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

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

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

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

Workers' Compensation
Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

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

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

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

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

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

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

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health 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 unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you paid us out-of-pocket in full. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

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

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office.

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

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

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

You have the right to receive notice of a security breach. We are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Complaints or Questions

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

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

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