

# Merrimack Smiles, PLLC

**Michel E. Couret, D.D.S.**

**Cara A. Coleman, D.M.D.**

**22 Greeley Street, Suite I 1, Merrimack, N.H. 03054**

## **Financial Guidelines**

### **Patient with dental benefit program:**

Most dental benefit plans require the patient to be financially responsible for a portion of procedural fees; this is an out-of-pocket expense payable by the patient at the time of service.

### **Patient with primary and secondary benefit plans: (Coordination of benefits)**

With such a wide variety of benefit plans to coordinate, it is impossible for us to predict what the secondary insurance will cover. Each plan has its own policy stating what will be covered when a second plan is involved. As a service to you, we will submit to your secondary carrier to maximize your benefits. You are responsible for any unpaid portion not covered by your benefit plans.

### **Patients without dental benefit coverage:**

Patients should come prepared to pay for dental services on the day treatment is rendered. For your convenience checks, cash, **MasterCard, Visa, American Express, Capital One/Healthcare and Citihealth Card** are accepted.

**Pre-Payment** plans are available. Any payment arrangements will need to be made with our front office staff prior to the appointment.

### **General Office Policy:**

**Returned checks:** There will be a \$25.00 charge for all returned checks.

**Cancelled or missed appointments:** We require (2) two business days advanced notice or there will be a minimum charge of \$50.00.

**I understand and agree to the above financial guidelines.**

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(Signature Patient/Guardian)

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(Date)

**CONFIDENTIAL INFORMATION**

**Michel E. Couret, D.D.S. & Cara A. Coleman, D.M.D.**  
**Merrimack Smiles, PLLC**

**Responsible Party:**

Name of Patient \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Birthdate \_\_\_\_\_ **Check One:** Mr.  Mrs.  Ms.  Miss  Dr.  Prof.

Name of Person Responsible for This Account \_\_\_\_\_

Relationship to patient: Self Spouse Parent Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name & Phone Number of Two Adults **NOT** Living in Your Household (in case of emergency).

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Do you have an **E-Mail address** that you check often? \_\_\_\_\_

**PRIMARY DENTAL INSURANCE INFORMATION:**

**Check if No Insurance:**  NO

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ SS#/ID# \_\_\_\_\_ Work phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Dental Benefit Company \_\_\_\_\_ Group # \_\_\_\_\_

Dental Benefit Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dental Benefit Company Phone \_\_\_\_\_ Maximum Annual Benefit \$ \_\_\_\_\_

**DO YOU HAVE AN ADDITIONAL DENTAL BENEFIT PLAN?**  Yes  No (if Yes, complete the following.)

**SECONDARY DENTAL BENEFIT PLAN INFORMATION:**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/ID# \_\_\_\_\_ Work phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Maximum Annual Benefit \$ \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dental Benefit Company \_\_\_\_\_ Group # \_\_\_\_\_

Dental Benefit Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**\*\* PLEASE HAVE YOUR DENTAL BENEFIT CARD READY FOR US TO PHOTOCOPY.\*\***

**Confidential Medical/Dental History Merrimack Smiles, PLLC Michel E. Couret, D.D.S. & Cara A. Coleman, D.M.D.**

Patient (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

What would you like us to call you? (Nickname/other) \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer (if applies) \_\_\_\_\_ Social Security # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female  Single  Married  Divorced  Widowed  Separated Height \_\_\_\_\_ Weight \_\_\_\_\_

Check one:  Name of Spouse /  Parent /  Life Partner /  Significant other /  Fiance \_\_\_\_\_

Drivers License # \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Contact person in case of any medical emergency. \_\_\_\_\_ Phone: \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_

An active e-mail account that you check often: \_\_\_\_\_

**Please check YES or NO.** If you do not know the correct answer please write **"Don't Know"** after the question.

	Yes	No		Yes	No
How long since your last dental visit? _____			Have you ever had an accident involving head, neck or back injuries? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of any dental problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	Date of accident _____		
Are you in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>	Any congenital abnormalities? Please Indicate type. _____		
Has there been any change in your general health within the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you been/or are you on aspirin therapy? .....	<input type="checkbox"/>	<input type="checkbox"/>
My last physical examination was on _____			Have you been/ or are you taking St. John's Wort? .....	<input type="checkbox"/>	<input type="checkbox"/>
Name and address of primary care M.D. (PCP) _____			Have you ever taken Phen-fen, Redux, Celebrex or Vioxx? (circle one) .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any serious illness, operation, or been hospitalized in the past 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have epilepsy or other neurological disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what was the illness or problem? _____			Do you have any artificial joints/prosthesis? What area? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you on a diet at this time? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you/or have you ever had T.B? (Tuberculosis) .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sleep apnea? (CPAP machine?) .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke, chew or use any other form of tobacco? (Which? _____)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any hearing loss? .....	<input type="checkbox"/>	<input type="checkbox"/>	Problems of the immune system? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high cholesterol? .....	<input type="checkbox"/>	<input type="checkbox"/>	explain problem _____		
Do you/did you have any type of cancer? .....	<input type="checkbox"/>	<input type="checkbox"/>	Problems with mental health? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any radiation/chemo treatment, for a tumor, growth or other condition? (circle one) .....	<input type="checkbox"/>	<input type="checkbox"/>	Depression? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any blood disorder such as anemia or leukemia, etc.? (Circle which one) .....	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had abnormal bleeding? .....	<input type="checkbox"/>	<input type="checkbox"/>	Are you/have you been on any type of Osteoporosis medication? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever required a blood transfusion? .....	<input type="checkbox"/>	<input type="checkbox"/>			
Are you ADHD or ADD? .....	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have headaches/migraines? .....	<input type="checkbox"/>	<input type="checkbox"/>			
Explain: _____					

**Confidential Medical/Dental History, Continued (page 2)**

**Do you have or have you had any of the following diseases or problems? Please check appropriate answer.**

	Yes	No
Damaged, leaky or artificial heart valves? .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur or rheumatic heart disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, or stroke? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have low blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chest pain upon exertion? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you ever short of breath after mild exercise or when lying down? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do your ankles swell? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Fibromyalgia? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have inborn heart defects? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker or heart valve implant? .....	<input type="checkbox"/>	<input type="checkbox"/>

**Are you allergic or have you had a reaction to:**

Local anesthetics or novocaine? .....	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to latex? .....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics? .....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills? .....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin? .....	<input type="checkbox"/>	<input type="checkbox"/>
Iodine? .....	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics? .....	<input type="checkbox"/>	<input type="checkbox"/>
Pollens, hay fever, etc? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you sensitive or allergic to metals? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been tested for metal allergy? .....	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Respiratory problems, emphysema, bronchitis, etc? .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney trouble? .....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in neck? .....	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have syphilis? .....	<input type="checkbox"/>	<input type="checkbox"/>

**Are you taking any medications(s) including vitamins, Nonprescription or homeopathic medicines, aspirins, etc. Please list:** .....

	Yes	No
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____		

**Prescribing Physician**

\_\_\_\_\_

**Would you like to speak to the doctor privately about any problems?** .....

	<input type="checkbox"/>	<input type="checkbox"/>
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Yes No

Sinus trouble? .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures? .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever tested positive for Hepatitis, Jaundice or liver disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Aids? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested positive for HIV? .....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent diarrhea or recent weight loss? .....	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux, Hiatal Hernia, Colitis or Irritable Bowel Syndrome? .....	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcer or hyperacidity or GERD? .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any inflammatory disease such as arthritis, rheumatism, or painful swollen joints? .....	<input type="checkbox"/>	<input type="checkbox"/>

**Has anyone ever told you that you need pre-medication for dental treatment?**

	<input type="checkbox"/>	<input type="checkbox"/>
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**Name of prescription**

\_\_\_\_\_

Are you wearing any removable partials dentures? (check which) .....

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

Do you have/wear retainers, a mouth guard or a night guard? (check one) .....

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

**Are you happy with your smile?** .....

	<input type="checkbox"/>	<input type="checkbox"/>
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What changes would you make?

\_\_\_\_\_

Have you ever considered whitening your teeth? (or did you?) .....

	<input type="checkbox"/>	<input type="checkbox"/>
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Have you had any serious trouble associated with any previous dental treatment? .....

	<input type="checkbox"/>	<input type="checkbox"/>
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If "Yes", what:

\_\_\_\_\_

\_\_\_\_\_

**FOR WOMEN ONLY:**

**Are you pregnant?** .....

	<input type="checkbox"/>	<input type="checkbox"/>
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**Are you nursing?** .....

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

**Do you have any problems associated with your menstrual period?** .....

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

**Are you taking birth control pills or Hormone Replacement Therapy?** .....

	<input type="checkbox"/>	<input type="checkbox"/>
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**How many children do you have?** \_\_\_\_\_

\_\_\_\_\_



\_\_\_\_\_  
Patient Name

**Michel E. Couret, D.D.S.      Cara A. Coleman, D.M.D.**  
**Merrimack Smiles, PLLC at the Medallion Center**  
**22 Greeley Street Suite 11**  
**Merrimack, NH 03054**

\_\_\_\_\_  
Date

Check One:

- My mouth is  a.) very comfortable  
 b.) moderately comfortable  
 c.) uncomfortable

- I aspire to a mouth with:  a.) excellent health  
 b.) good health  
 c.) poor health

- I / I am  a.) think the appearance of my mouth is excellent  
 b.) satisfied with the appearance of my mouth  
 c.) dissatisfied with the appearance of my mouth

What are some questions about dentistry and oral health that you have never had adequately answered?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- I  a.) will do anything to keep my natural teeth  
 b.) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.

If there is anything you would change about your smile, what would it be?

\_\_\_\_\_  
\_\_\_\_\_

- I  a.) have set goals for my oral health with a previous dentist.  
 b.) want to set goals concerning my dental health.  
 c.) never set goals concerning my oral health.

If you are a new patient, what is important to you about your dental visits?

\_\_\_\_\_  
\_\_\_\_\_

- I  a.) have always done the best that was recommended for my dental health.  
 b.) have not done what dentists have recommended for my mouth.  
 c.) rarely go, and don't care much about any dental work completed.

If you have been with us for awhile, how could we improve your experience with us?

\_\_\_\_\_  
\_\_\_\_\_

- I have  a.) put dentistry for myself and my family high on my priority list.  
 b.) put dentistry for myself and my family low on my priority list.  
 c.) it is on my list but hard to find.

Dentistry is not a priority because: (check those which apply)

a.) time  b.) cost  c.) fear  d.) other  \_\_\_\_\_

- I think my present state of dental health is:  a.) excellent  
 b.) good  
 c.) poor

Date \_\_\_\_\_ Staff \_\_\_\_\_ MEC \_\_\_\_\_ CAC \_\_\_\_\_

Thank you for completing this form. Should you have a concern now or in the future we would be pleased to meet with you privately.



**CONSENT TO USE OR DISCLOSE  
DENTAL AND MEDICAL INFORMATION**

I authorize **Michel E. Couret, D.D.S. and Cara A. Coleman, D.M.D.** to use and disclose the dental, medical and health information of \_\_\_\_\_ for  
(name of patient)  
the following purpose(s).

**Treatment** - includes activities performed by a dentist or dental hygienist, as well as coordinating or managing care provided to you with third parties, and consultations involving dentists, physicians, and other health care providers.

**Payment** - includes activities involved in determining whether you are eligible for dental plan coverage, billing matters, and reimbursement for your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, precertification and preauthorization of services.

**Health Care Operations** - includes associated business and administrative affairs of this Office.

**Other** (explain):

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You have the right to revoke this Consent. However you must revoke this consent **in writing**. Any revocation would not pertain to information already used or disclosed pursuant to this Consent during the time frame within which this Consent is effective.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of guardian or other person authorized by law

**Michel E. Couret, D.D.S.**  
**Cara A. Coleman, D.M.D.**

Merrimack Smiles, PLLC  
Medallion Center, 22 Greeley Street, Suite 11  
Merrimack, NH 03054 (603) 424-7676

**Merrimack Smiles, PLLC**  
Michel E. Couret, DDS      Cara A. Coleman, DMD  
22 Greeley Street, Suite 11, Merrimack, NH 03054

## **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. The privacy of your health information is important to us.

### **OUR LEGAL DUTY**

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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 applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and health care operations. For example:

**TREATMENT:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

**PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another healthcare provider or entity that is subject to the federal privacy rules for its payment activities.

**HEALTH CARE OPERATIONS:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**ON YOUR AUTHORIZATION:** You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us in authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**TO YOUR FAMILY AND FRIENDS:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

**APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**DISASTER RELIEF:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**PUBLIC BENEFIT:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;

- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates, and
- as authorized by state worker's compensation laws.

### **PATIENT RIGHTS**

**ACCESS:** You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may – but are not required to – prepare a summary or an explanation of your health information for fee. Contact us using the information listed at the end of this Notice for more information about fees.

**DISCLOSURE ACCOUNTING:** You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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 these additional requests. Contact us using the information listed at the end of this Notice for more information about fees.

**RESTRICTION:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency). Any agreement we make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

**ALTERNATIVE COMMUNICATION:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or locations you request.

**AMENDMENT:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below:  
If you believe that:

- we may have violated your privacy rights;
- we made a decision about access to your health information incorrectly;
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by an alternative means or at alternative locations,

You may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address 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.

Office Contact: Karen Lambert, Office Manager, Privacy Officer  
Telephone: (603) 424-7676 Fax: (603) 429-2092  
E-mail: [mecouretdds@comcast.net](mailto:mecouretdds@comcast.net)  
Address: Merrimack Smiles, PLLC, (Michel E. Couret, DDS)  
22 Greeley Street, Suite 11, Merrimack, NH 03054

**AUTHORIZATION FOR USE OR DISCLOSURE  
OF DENTAL/HEALTH INFORMATION**

I authorize **Michel E. Couret, D.D.S.** and **Dr. Cara A. Coleman, D.M.D. (Merrimack Smiles, PLLC)** to use and disclose a copy of the specific dental, medical and health information described below regarding

\_\_\_\_\_  
(Name of patient)

consisting of: \_\_\_\_\_ Conversations about treatment, financial and appointments \_\_\_\_\_

\_\_\_\_\_  
(Describe information that is the subject of use or disclosure)

to: \_\_\_\_\_

\_\_\_\_\_  
(Name and address of recipient or class of recipients)

for the purpose of: \_\_\_treatment, financial, appointment and other miscellaneous information \_\_\_\_\_

\_\_\_\_\_  
(Describe *each* purpose of disclosure)

If we are requesting this Authorization from you for use in our practice and disclosure, or to permit another Dentist or other health care provider or dental or health plan to disclose information to us:

1. Our rendering of dental services or treatment to you is not contingent upon the receipt of this signed Authorization:
2. You may inspect a copy of the protected dental or health information to be used or disclosed;
3. You may refuse to sign this **Authorization For Use Or Disclosure of Dental/Health Information**; and
4. We must provide you with a copy of the signed Authorization.

You may revoke this Authorization at any time. **However, you must revoke this Authorization only in writing.**

Any revocation would not pertain to information already used or disclosed based on this Authorization during the time frame within which the Authorization is effective.

**I have reviewed and understand this Authorization. I also understand that any information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient. If such re-disclosure occurs, the information will no longer be protected under federal law.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient

or

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient's representative

\_\_\_\_\_  
Description of representative's authority

**Michel E. Couret, D.D.S.**

**Merrimack Smiles, PLLC**  
22 Greeley Street, Suite 11, Merrimack, NH 03054-4460

**Cara A. Coleman, D.M.D.**  
603-424-7676