Merrimack Smiles

Patient and Insurance Information

Name of Patient _____ Today's Date _____

Patient's Birth date _____ **Circle 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? _____

If not eligible for dental insurance, please circle NO

PRIMARY DENTAL INSURANCE INFORMATION:

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 (SECONDARY) DENTAL BENEFIT PLAN? ***Yes No***

(if Yes, complete the following:)

Name of Insured _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip_____

Birth date _____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. ****

Merrimack Smiles

Smile Questionnaire

Patient Name: _____ Date: _____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

How would you describe your mouth? (circle one)

Very comfortable Moderately comfortable Uncomfortable

I think my present state of dental health is: (circle one)

Excellent Good Poor

I have put dentistry for myself and my family _____ on my priority list: (circle one)

High Low Not a priority

Please check the statement which you feel is accurate:

☐ I will do anything to keep my natural teeth.

☐ I want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.

☐ I go to the dentist only when my tooth/teeth hurt, and don't care much about any dental work.

Staff_____ MSM_____

Merrimack Smiles

Health History Form

Referred By: **Today's Date:**

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Legal Name: _____ **Preferred Name (Nickname):** _____
Last **First** **Middle Initial**

Address: _____
City **State** **Zip**

Occupation: _____ **Cell Phone:** _____ **Home Phone:** _____

SS# _____ **Date of Birth** _____ **Height** _____ **Weight**_____ **Sex: M F**

Emergency Contact _____ **Relationship** _____ **Phone** _____

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

Your Name _____ **Relationship** _____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)	**Yes**	**No**	**DK**
Active Tuberculosis	O	O	O
Persistent cough greater than a 3 week duration	O	O	O
Cough that produces blood	O	O	O
Been exposed to anyone with tuberculosis	O	O	O

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information (Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do your gums bleed when you brush or floss?	O	O	O
Are your teeth sensitive to cold, hot, sweets or pressure?	O	O	O
Does food or floss catch between your teeth?	O	O	O
Is your mouth dry?	O	O	O
Have you had any periodontal (gum) treatments?	O	O	O
Have you ever had orthodontic (braces) treatment?	O	O	O
Have you had any problems associated with previous dental treatment?	O	O	O
Is your home water supply fluoridated?	O	O	O
Do you drink bottled or filtered water?	O	O	O

If yes, How often? Circle one: DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	O	O	O

What is the reason for your dental visit today?

	Yes	No	DK
Do you have earaches or neck pains?	O	O	O
Do you have clicking, popping or discomfort in the jaw?	O	O	O
Do you clench or grind your teeth?	O	O	O
Do you have sores or ulcers in your mouth?	O	O	O
Do you wear dentures or partials?	O	O	O
Do you participate in active recreational activities?	O	O	O
Have you ever had a serious injury to your head or mouth?	O	O	O

Date of your last dental exam: _____

What was done at that time: _____

Date of last dental x-rays: _____

How do you feel about your smile?

Medical Information (Check DK if you don't know the answer to the question)

	Yes	No	DK
Are you now under the care of a physician?	O	O	O

Physician Name: _____

Physician Address/City State/Zip _____

Phone Number: _____

Are you in good health?	O	O	O
Has there been any change in your general health within the past year?	O	O	O

If yes, what condition is being treated? _____

Date of last physical exam: _____

	Yes	No	DK
Do you wear contact lenses?	O	O	O
Have you had a serious illness, operation or been hospitalized in the past 5 years?	O	O	O

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	O	O	O

If Yes, please list all, including vitamins, natural or herbal medications and/or diet supplements:

	Yes	No	DK
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	O	O	O
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	O	O	O
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	O	O	O

Date Treatment began: _____

	Yes	No	DK
Do you use controlled substances (drugs)?	O	O	O
Do you use tobacco? (smoking, snuff, chew)?	O	O	O

If so, how interested are you in stopping?
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?	O	O	O

If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink in a week? _____

WOMEN ONLY:

Are you:			
Pregnant?	O	O	O
Number of weeks _____			
Taking birth control or hormonal replacement?	O	O	O
Nursing?	O	O	O

Joint replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? **Yes No**

If yes, Date: _____ **If yes, have you had any complications? Yes No Specify:**_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Name of physician or dentist making recommendation: **Phone:**

Allergies – Are you allergic to or have you had a reaction to: If **Yes**, Specify reaction.

	Yes	No	DK	Type of Reaction
Local anesthetics	O	O	O	
Aspirin	O	O	O	
Penicillin or other antibiotics	O	O	O	
Barbiturates, sedatives, or sleeping pills	O	O	O	
Sulfa drugs	O	O	O	
Codeine or other narcotics	O	O	O	
Metals	O	O	O	
Latex (rubber)	O	O	O	
Iodine	O	O	O	
Hay fever/seasonal	O	O	O	
Animals	O	O	O	
Food	O	O	O	
Other:				

	Yes	No	DK
Heart Murmur	O	O	O
Mitral valve prolapse	O	O	O
Artificial heart valves	O	O	O
Rheumatic fever	O	O	O
Cardiovascular disease	O	O	O
Angina	O	O	O
Arteriosclerosis	O	O	O
Congestive heart failure	O	O	O
Coronary artery disease	O	O	O
Damaged heart valves	O	O	O
Heart attack	O	O	O
Low blood pressure	O	O	O
High blood pressure	O	O	O
Abnormal bleeding	O	O	O
Anemia	O	O	O
Rheumatic heart disease	O	O	O
Congenital heart defect	O	O	O
Pacemaker	O	O	O
Hemophilia	O	O	O
Blood transfusion	O	O	O
Date:			

	Yes	No	DK
AIDS or HIV infection	O	O	O
Arthritis	O	O	O
Autoimmune disease	O	O	O
Rheumatoid arthritis	O	O	O
Systemic lupus erythematosus	O	O	O
Asthma	O	O	O
Bronchitis	O	O	O
Emphysema	O	O	O
Sinus trouble	O	O	O
Tuberculosis	O	O	O
Cancer/Chemotherapy/ Radiation Treatment	O	O	O
Chest pain on exertion	O	O	O
Chronic pain	O	O	O
Diabetes	O	O	O
Circle one : Type I or II			

	Yes	No	DK
Eating disorder	O	O	O
Malnutrition	O	O	O
Gastrointestinal Disease	O	O	O
G.E. Reflux/persistent	O	O	O
Heartburn	O	O	O
Ulcers	O	O	O
Thyroid problems	O	O	O
Stroke	O	O	O
Glaucoma	O	O	O
Hepatitis, jaundice or liver disease	O	O	O
Fainting spells or seizures	O	O	O
Excessive urination	O	O	O
Neurological disorder	O	O	O
Specify:			

	Yes	No	DK
Epilepsy	O	O	O
Sleep disorder	O	O	O
Mental health Disorder	O	O	O
Specify:			
Recurrent infections	O	O	O
Type of infection:			
Kidney problems	O	O	O
Night sweats	O	O	O
Osteoporosis	O	O	O
Persistent swollen glands in neck	O	O	O
Severe headaches/ Migraines	O	O	O
Severe or rapid weight loss	O	O	O
Sexually transmitted Disease	O	O	O

Do you have any disease, condition or problem not listed above that you think the doctor should know about? Please circle: Yes No
If Yes, please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____ _____

Signature **of Patient/Legal Guardian** **Date** **Signature of Doctor**

Merrimack Smiles

Financial Agreement

We are honored that you have chosen us to provide your dental care. Our belief is that all of our **patients deserve honesty, information and respect**. Our agreement exists because of our respect for **your right to know ahead of time** what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement do not hesitate to ask any of our office staff.

1. **PAYMENT POLICY:** Payments are to be made at the time of services rendered by cash, personal check and Visa, MasterCard, Discover or Amex credit cards. We also offer a 0% interest Care Credit Dental Treatment Financing Program as an additional option to help you accept your necessary dental treatment.

   A treatment acceptance discount is available for treatment plans, greater than $1,000. The payment must be paid for <u>all</u> recommended treatment; on the day treatment is presented. A treatment acceptance discount of 5% will be given if paid by check or cash and a 2.5% discount if paid by credit, debit or HSA. If any dental benefits are available, the discount will be applied to only the patient portion of the treatment.

   INITIAL _____

2. **MINOR PATIENTS:** The **parent or guardian accompanying** the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, **without any exception, at the time of service**. **Merrimack Smiles will not attempt to collect payment from a parent that is not present in the office at that visit.**

   INITIAL _____

3. **RETURNED CHECKS:** A **$25.00** charge applies when a check is returned by the bank.

   INITIAL _____

4. **LATE PAYMENT FEE AND COLLECTION FEES:** Late payment fees **will be applied to all balances not paid within thirty (30) days of the monthly billing date**. A **late charge of 2.0%** on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to pay promptly so you can avoid late payment fees. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on any outstanding account balance. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

   INITIAL _____

5. **OVERDUE BALANCE:** An account with an **unpaid non-insurance benefit balance past ninety (90) days** will be sent to the collection agency. At that time, **you will be responsible for any and all costs incurred in the collection of your debt** including the unpaid balance from our services provided, attorney fees, court fees and any other fees associated with the collection of your debt.

   INITIAL _____

6. **CANCELLATION POLICY:** Scheduled appointments are specifically reserved for you. Our method of contact is by email, text messages and phone calls. We will help remind you of your next appointment by contacting you by the preferred method you have identified two (2) business days in advance. If your preferred contact method is by telephone and we are unable to speak with you directly, we will leave you a voice message reminder.

   If you cannot keep a scheduled appointment **we require a minimum of <u>two (2) business days advance notice</u>** from the time of your appointment to cancel or reschedule your appointment. This will allow our office adequate time to provide services for another patient in need. **Leaving a message on our office voicemail** the night before or during the weekend for a Monday appointment **does not qualify as two (2) business days advance notice**. If you are more than 15 minutes late to your appointment it will be considered a broken appointment.

   We take broken or missed appointments seriously because it can take limited clinical appointments from other patients in need. A $75.00 broken or missed appointment fee will be charged for each scheduled appointment commitment not met. We reserve the right to dismiss patients from the practice who have a chronic history of broken or missed appointments.

   INITIAL _____

7. **EXTENDED OR SPECIAL HOURS CANCELLATION POLICY:** We may offer extended business hour appointments for specific types of treatment to accommodate our patients. To reserve your appointment time for an extended hours appointment we require payment in full of your out of pocket costs for the treatment scheduled to be provided at the time of booking. Cancellation of an extended hour appointment **will require two (2) business days' notice and follow the identical cancellation requirements as described in number six (6) above, with the exception of a <u>$150 broken or missed appointment fee</u> will be assessed and subtracted from the funds used to reserve your appointment time.** In the event of an emergency your deposit can be applied to the rescheduled appointment (i.e. last-minute business commitments or no childcare is NOT considered an emergency).

   We reserve the right to not offer extended or special hour appointments to patients with a history of missed or broken appointments.

   INITIAL _____

I understand and am in agreement to the financial policy of Merrimack Smiles, as written above.

_____ _____

Patient/Parent/Guardian (Print) Date

_____

Patient/Parent/Guardian Signature

Merrimack Smiles

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT WITH OR WITHOUT DENTAL INSURANCE

DENTAL INSURANCE: As a courtesy we will gladly file your dental claims and accept all or partial payment in the form of your insurance benefits, provided you agree to the following:

Your insurance plan is a contract between your employer, the insurance company and you. **Merrimack Smiles is not a party to that contract, our involvement with you and your insurance company is a courtesy we provide**. As a courtesy to all patients we will verify your dental insurance benefits **upon request**, to the best of our ability. However, **you are ultimately responsible to know your plan coverage benefits, exclusions and limitations waiting periods, etc**. You should also **be aware of non-covered benefits** such as missing tooth clauses, crown/bridge/denture restorations, bruxism, downgraded limitations for fillings and porcelain on crowns on molar teeth, frequency limits for exams, prophylaxis (cleanings), fluoride and x-rays, etc.

While we may be capable of providing you an estimate of your available insurance benefits, please keep in mind they are **only estimates** and not guarantees. You are responsible to know our fees and not just what your insurance company allows or considers "usual, customary and reasonable", which can vary from one company to another. If your employer changes insurance plans you need to inform us otherwise we will not know a change has occurred and your estimated benefits may not be accurate. Choosing to receive our services indicates your acceptance of responsibility **to pay regardless of our estimate**. **All estimates are subject to final approval by your dental insurance plan**; therefore the amount due is subject to change after final explanation of benefits have been paid.

All **charges not paid by your insurance company are your responsibility** regardless of the reason for nonpayment. **Not all the services we provide for your optimal care are covered benefits**. Covered benefits can differ depending on the insurance provider and type of plan purchased by your employer.

The **estimated amount not covered by your insurance is due at the time of treatment** and may be paid by cash, personal check and Visa, MasterCard, Discover or Amex credit cards. We also offer a 0% interest Care Credit Dental Treatment Financing Program as an additional financing option, to help you pay for your necessary dental treatment.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees and **payment is expected at each visit for services rendered**.

I understand and am in agreement to my responsibility, knowledge and obligation regarding compensation for services rendered by Merrimack Smiles with or without dental insurance coverage.

_____ _____

Patient/Parent/Guardian (Print) Date

_____

Patient/Parent/Guardian Signature

Merrimack Smiles

AUTHORIZATION FOR USE OR DISCLOSURE OF DENTAL/HEALTH INFORMATION

I, _____, authorize the Doctors of Merrimack Smiles
(Name of patient)

to use and disclose a copy of the dental, medical and health information described below regarding:

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 our dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, pre-certification and preauthorization of services.

Health Care Operations – includes associated business and administrative affairs of this office.

Individual Consent – include anyone with whom you give consent for us to provide confidential information with.

Please specify individual(s) name(s), relationship and specify what type of information you give consent for us to share.

_____
(Name(s), relationship(s) and type of information)

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:

- Our rendering of dental services or treatment to you is not contingent upon the receipt of this signed Authorization:
- You may inspect a copy of the protected dental or health information to be used or disclosed:
- You may refuse to sign this **Authorization for Use or Disclosure of Dental/Health Information;** and
- 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 IN WRITING ONLY.** 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, information will no longer be protected under federal law.

_____ _____
Signature of patient Date

_____ _____
Signature of patient's representative Date

_____
Description of representative's authority

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE (HIPAA)

Instructions: If you are signing this form on behalf of someone else please also fill out Section B with your information.

Section A: The Patient

Print Name: _____

Signature: _____

Date: _____

Section B: Patient Representative

If a personal representative signs this authorization on behalf of the individual, complete the following:

_____
Personal Representative's name

_____
Relationship to Individual

******PLEASE RETAIN FOR YOUR RECORDS****** **Merrimack Smiles**

NOTICE OF PRIVACY PRACTICES

Revised to reflect the 2013 HIPAA/HITECH Omnibus Final Rule

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 05/01/2014 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 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 (e-mail).

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 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.