

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED
PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
STATE/ PROV. _____ ZIP/ P.C. _____

BUSINESS ADDRESS _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/ PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X

SIGNATURE

PATIENT NAME _____
 HOME ADDRESS _____

 E-MAIL _____
 BUSINESS ADDRESS _____

TODAY'S DATE _____
 DATE OF BIRTH _____
 HOME PHONE _____
 CELL PHONE _____
 BUSINESS PHONE _____
 SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

YES NO

1. ARE YOU UNDER MEDICAL TREATMENT NOW? ☐ YES ☐ NO

2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? ☐ YES ☐ NO

3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? ☐ YES ☐ NO
 IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____

4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX? ☐ YES ☐ NO

5. DO YOU USE TOBACCO? ☐ YES ☐ NO

6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? ☐ YES ☐ NO

7. ARE YOU WEARING CONTACT LENSES? ☐ YES ☐ NO

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> LOCAL ANESTHETICS (E.G. NOVOCAINE)	<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> ASPIRIN
<input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/> SEDATIVES	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> IODINE	

9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? ☐ YES ☐ NO

10. WOMEN ONLY:

A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? ☐ YES ☐ NO

B) ARE YOU NURSING? ☐ YES ☐ NO

C) ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> CHEST PAINS
<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> CARDIAC PACEMAKER	<input type="checkbox"/> EASILY WINDED
<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> STROKE
<input type="checkbox"/> SWOLLEN ANKLES	<input type="checkbox"/> ANGINA	<input type="checkbox"/> HAY FEVER / ALLERGIES
<input type="checkbox"/> FAINTING / SEIZURES	<input type="checkbox"/> FREQUENTLY TIRED	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> RADIATION THERAPY
<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> EPILEPSY / CONVULSIONS	<input type="checkbox"/> CANCER	<input type="checkbox"/> RECENT WEIGHT LOSS
<input type="checkbox"/> LEUKEMIA	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LIVER DISEASE
<input type="checkbox"/> DIABETES	<input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/> HEART TROUBLE
<input type="checkbox"/> KIDNEY DISEASES	<input type="checkbox"/> HEPATITIS / JAUNDICE	<input type="checkbox"/> RESPIRATORY PROBLEMS
<input type="checkbox"/> AIDS OR HIV INFECTION	<input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> THYROID PROBLEM	<input type="checkbox"/> STOMACH TROUBLES / ULCERS	

COMMENTS

SIGNATURE OF DENTIST

DATE

PATIENT DENTAL HISTORY

YES NO	YES NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? <input type="checkbox"/> YES <input type="checkbox"/> NO	8. DO YOU HAVE FREQUENT HEADACHES? <input type="checkbox"/> YES <input type="checkbox"/> NO
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO	9. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO	10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? <input type="checkbox"/> YES <input type="checkbox"/> NO	12. HAVE YOU HAD ANY ORTHODONTIC WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO
A) CLICKING? <input type="checkbox"/> YES <input type="checkbox"/> NO	15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
B) PAIN (JOINT, EAR, SIDE OF FACE)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
C) DIFFICULTY IN OPENING OR CLOSING? <input type="checkbox"/> YES <input type="checkbox"/> NO	
D) DIFFICULTY IN CHEWING? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X

Dr. Darcie L. Lee

Payment Responsibility and Authorization

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fee with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask, if you have any questions about our fees, financial policy or your responsibility in this matter.

- All patients must complete our "patient information" form before seeing a doctor. It is patient's responsibility to inform us of any changes in this information, including: address, telephone number employment, insurance coverage, ect.
- Your portion of insurance is due at the time of service.
- We accept cash, checks and credit cards as methods of payment. We also participate with Care Credit.
- Balances older than 30 days will be subject to additional collection fees and charges.
- Returned checks will be charged a \$30.00 service fee.

Unaccompanied minors: Parents or guardians are responsible for full payment. Non-emergency treatment may be denied unless charges have been preauthorized to an approved credit card or paid by cash/check.

Regarding Insurance: If you have insurance, we are anxious to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. You must realize, however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are NOT a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies and therefore are covered up to the maximum allowance determined by each carrier. However we are NOT a preferred provider with any insurance company, and if they do not pay the balance due in this office, it becomes YOUR responsibility to pay in full the remaining portion of the charges incurred.
3. Not all services are covered benefits in all contracts. Your employer selects and defines the services covered in your policy.
- 4.

We must emphasize that as medical providers, our responsibility is with YOU our patient, not your insurance company. While we gladly file your insurance claims on your behalf, it is essential that you understand that this is provided as a courtesy that we extend all of our patients, and all charges are still your responsibility for the dates of service rendered.

You are expected to pay your bill at the time of your visit, or if insurance is being filed, an ESTIMATE of your part of the bill. Any remaining balance due after your insurance company has made payment is your responsibility. This balance is expected to be paid in full.

All past due Balances are subject to additional charges, and any account which requires collection agency intervention will be subject to additional fees, as well.

It is our intention and hope that this written policy will eliminate any future misunderstandings between our office and our patients.

I hereby authorize the release of any medical or other information necessary to process insurance claims and I hereby authorize payment of dental benefits to Dr. Darcie Lee for all services rendered if full payment is not made at the time of service. This authorization applies to all occasions of service until resolved.

Signature of responsible party below:

Signature_____

Date_____

DENTAL CONSENT FORM

To whom it may concern,

I _____, give my consent for Dr. Darcie L. Lee and members of their dental team to discuss my dental records, dental treatment, and give my permission to pick up a copy of dental x-rays, and pick up a copy of dental records to the following person(s)

1. _____
2. _____
3. _____
4. _____

Please initial by each of the following statements:

____ I give my consent for Dr. Darcie L. Lee and members of their dental team to leave messages about my appointment on my home answering machine, my cell phone voice mail and or any family members of my household that answers the phone.

____ I give my consent for Dr. Darcie L. Lee and members of their dental to take photos, dental x-rays, and to provide treatment as necessary. I understand that dental x-rays are necessary to diagnose cavities.

____ I give my consent for Dr. Darcie L. Lee's office to release all x-rays to another professional practice when requested.

I hereby authorize the release of my medical/dental records and dental x-rays to:

Dr. Darcie L. Lee
3320 Whiskey Rd.
Aiken, S.C. 29803
803-642-4564
FAX 803-642-4515
Email: smileaiken@gmail.com

Print Patient Name

Date of Birth

Signature of Patient/guardian

Date

PRACTICE NAME

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have reviewed/received a copy of

Patient Name

_____'s Notice of Privacy Practices.

Practice Name

Signature of Patient / Guardian

Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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NOTICE OF PRIVACY FOR DENTAL PRACTICE

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

Effective Date of this notice: April 14, 2003

Name of Practice

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

We work in open treatment areas. We will attempt to keep your personal health information (PHI) to the minimum.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or cleaning at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Products and Services

We may tell you about health related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, nonaccidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or Xrays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*.

We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our privacy official in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our privacy official. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our privacy official. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit a *Request For Restricting Uses and Disclosures and Confidential Communications Form* Information to our privacy official.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Requests For Restricting Uses and Disclosures and Confidential Communications* to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our privacy official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

To file a complaint with our office, contact our privacy official. You will not be penalized for filing a complaint.