10-22-2012

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Thank you so much for contacting our office. We are excited to meet you and welcome you as a new patient! Your health and proper care are very important to us. So that we may seat you on time, we ask you to fill out the attached new patient registration forms and bring them with you to your scheduled appointment. Below is an explanation to better assist you with the forms.

Included in the packet you will find a:

Dental Benefits Verification Form that is a guide for you to double check with your dental insurance plan to make sure you do not have any unexpected out of pocket co-pays, frequencies, or waiting periods, that you should be aware of. It is very important to have a basic idea of what is covered and what is not, before you receive services from any office. This form highlights the services that are usually performed in your first new patient visit and that may not always be listed on the fax we receive from your insurance company. This form should be filled out for each *family member* because waiting periods and history are specific to the person, rather than the insurance plan. **Often times, the way to locate most of your insurance information is to spend about 10 minutes on the website listed on your insurance card. Call your insurance if the information is not easily accessible or if you have questions.**

Patient Registration Form that requests basic individual and insurance information for the patient and the responsible party, along with emergency contacts, pharmacy, and doctor information.

Medical History Form that requests information regarding your health, medical history, current medications, allergies, and physician care. This is important to complete because oral health affects, and is affected by, overall health.

How Well Do You Sleep? Please fill out these assessments for patients 18 years and older.

Financial Policy that outlines accepted types of payments, available Care Credit financing, patient responsibility, payment due at the time of service, and the requirement of one full business day's, notice prior to canceling or rescheduling an appointment.

Privacy Practices (HIPAA) detailed policy and release form for you to sign and date after reading. Also please list names on this form of anyone we are able to speak with, regarding your account or treatment information**.**
You can update this form upon request at anytime.

General Education Photo Release Form (Optional) that allows us to display your anonymous photos, dental images, and radiographs for patient education.

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Please complete this form by calling your insurance company and bring it with you to your first appointment with your insurance card.

The information may also be online, depending on your insurance carrier. This form will help you determine if you will have any out of pocket expenses for your first visit. It will also help us provide you with a more accurate estimation of the cost of the treatment recommended by Dr. Strohmeyer. In addition to this form, we do request a fax from your insurance company. We have found that every insurance fax is different and this is some of the most important information that is not always on every fax. Please contact our office with any questions before your appointment regarding this form. A form should be completed for each family member.
Incomplete fields may cause a balance to be incurred.

REQUEST FOR DENTAL BENEFITS SPECIFIC PLAN INFORMATION

Patient Name: _____

Date of Call to Ins. Co. _____

Representative Name: _____

1) "Are there any *waiting periods on my insurance plan*?"

YES ☐ NO ☐

2) "Am I eligible for an FMX (D0210- this is the dental code, if needed)?"

YES ☐ NO ☐

3) "Are ALL X-RAYS covered at 100%?"

YES ☐ NO ☐

If no, specify: _____

4) "*Am I eligible* for a *Comprehensive Periodontal Exam* (D0180-this is the dental code, if needed)?"

YES ☐ NO ☐

AND is it covered at 100%

YES ☐ NO ☐

5) Am I eligible for an Adult Prophylaxis (Adult Cleaning D1110)?

YES ☐ NO ☐

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PATIENT REGISTRATION

First Name: _____ Middle Initial: _____ Last Name: _____
Preferred Name: _____
Patient is (circle all that apply): ☐ Policy Holder ☐ Responsible Party ☐ Neither ☐ Both

Patient Information

Street Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Wk #: _____

Birth Date: _____ Age: _____ SS #: _____

Sex: ☐ Male ☐ Female Drivers License #: _____ State: _____

Marital Status (circle one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Relationship to Insured (circle one): ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other

E-Mail Address if you would like to receive correspondences via e-mail: _____
Employment Status: ☐ Unemployed ☐ Full Time ☐ Part Time ☐ Retired
Student Status: ☐ Full Time ☐ Part Time # of Credit Hrs _____ School Name _____

Responsible Party *(Fill out this section <u>ONLY</u> if someone other than the patient is the Responsible Party*)

First Name: _____ Middle Initial: _____ Last Name: _____
Street Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell #: _____ Wk #: _____

Birth Date: _____ Age: _____ SS #: _____

Sex: ☐ Male ☐ Female Drivers License #: _____ State: _____

Marital Status (circle one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Relationship to Patient (circle one): ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other

E-Mail Address if you would like to receive correspondences via e-mail: _____
Employment Status: Full Time Part Time Retired

Primary Insurance Information

Name of Insured: _____
Birth Date: _____ SS#: _____
Employer: _____ Ins. Co. _____
Relationship to Patient: Self Spouse Child Parent Other

Secondary Insurance Information

Insured: _____
B-day: _____ SS#: _____
Employer: _____ Ins.Co. _____
Relationship: Self Spouse Child Parent Other

Emergency Contact Information:

Emergency Contact: _____ Emergency Phone #: _____
Emergency Contact: _____ Emergency Phone #: _____
Pharmacy Name: _____ Pharmacy #: _____
Primary Healthcare Physician: _____ Doctor #: _____
Specialist Physician (Name & Type): _____ Doctor #: _____

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MEDICAL HISTORY

Patient Name _____ Birth Date _____

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.

Are you under a physician's care now? ○ Yes ○ No If Yes, please explain: _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If Yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If Yes, please explain: _____

Are you taking any medication, pills, or drugs? ○ Yes ○ No If Yes, please list: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other mediations containing bisphosponates? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No _____

Do you use tobacco? ○ Yes ○ No _____

Do you use controlled substances? ○ Yes ○ No _____

Women: Are You

Pregnant? ○ Yes ○ No If Yes, What Trimester? _____ Trying to get pregnant? ○ Yes ○ No

Taking Oral Contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pace Maker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? If yes, please explain: _____

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 (patient's) health. It is my responsibility to inform the dental office of changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

STOP-BANG Questionnaire

1. Do you **Snore** loudly (louder than talking or loud enough to be heard through closed doors)?

   ☐ Yes ☐ No

2. Do you often feel **Tired**, fatigued, or sleepy during daytime?

   ☐ Yes ☐ No

3. Has anyone **Observed** you stop breathing during your sleep?

   ☐ Yes ☐ No

4. Do you have or are you being treated for high blood **Pressure**?

   ☐ Yes ☐ No

5. **Body** Mass Index (BMI) more than 35 (use the formula to calculate your BMI)?

   ☐ Yes ☐ No

   BMI Formula:

$$BMI = \frac{\textit{(your weight in pounds X 703)}}{\textit{(your height in inches X your height in inches)}}$$

6. **Age** over 50 yr old?

   ☐ Yes ☐ No

7. **Neck** circumference greater than 40 cm?

   ☐ Yes ☐ No

8. **Gender** male?

   ☐ Yes ☐ No

Scoring:

Answering "**yes**" to **three or more** of the 8 questions indicates that you are at **High Risk** for OSA. Answering "**yes**" to **less than three** questions indicates that you are at Low Risk for OSA. If you scored in the **High Risk for OSA** category, a **sleep study** or an **evaluation** by a **sleep specialist** may be warranted.

Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ **Your sex**: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

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

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	0

Score:	
0-10	Normal range
10-12	Borderline
12-24	Abnormal

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Matthew F. Strohmeyer, DDS, LLC

FINANCIAL POLICY

Thank you for choosing Dr. Strohmeyer as your oral health care provider and educator.
We are committed to providing the best care possible to all patients.

Our Financial Policy is in place to help our patients be aware that ***responsibility for verification of dental benefits and full payment of any account balance lies with each individual responsible party***. The responsible party is urged to research and be informed about his/her own insurance plan for assignment of benefits. Our office staff is here to provide you with help in understanding necessary treatment and filing claims promptly with required information to insurance.

The following statements explain our Financial Policy, Appointment Policy, and Insurance Acceptance Requirements in detail. We ask you to read all information carefully, then sign and return it prior to treatment.

- *Rescheduling or Canceling* an appointment requires 24 hours notice(10am Monday appointment can be changed no later than 10am on Fri)
- *We reserve the right to charge a fee* up to $25.00 per half hour of scheduled appointment for failed, late, or cancelled appointments
- *Full payment of treatment* is required at the time of service; insurance is accepted as partial payment and should be verified
- Returned Checks will result in a $20.00 charge to the patient's account plus any fees incurred from the banking institution
- *A Dental Benefits Verification Form* should be completed in full by the patient prior to treatment for estimated payments to be accepted by our office, or the office policy is to follow the information the insurance company provides via fax or website
- *An Explanation of Benefits* is released from the insurance company shortly after a claim is processed and it determines the patient responsibility-our office must collect the exact amount shown, any final balance is determined after this review
- *Patient is responsible for any balance* not covered by insurance
- *Patient is responsible for knowing and informing our office of any changes* that occur with an insurance plan- this allows our estimates to be as accurate as possible
- *Treatment will only be provided after* prior account balances are paid in full
- *Accepted Forms of payment include:* Cash, Checks, MasterCard and Visa.
- *Financing offered is available through Care Credit*, a health care credit card that allows payment plans with up to twelve months interest free (brochures and applications including same day approval is available at the front desk)
- *Some treatment may not be a covered benefit in an insurance plan* leaving the patient responsible for the dentist's full fee instead of a contracted fee (treatment plans may be given upon request for the patient to determine individual coverage)
- *It is possible and not uncommon in dentistry, that proposed treatment may need to change* during a procedure-we recommend allowing a 20% variance on any estimated service amount or treatment plan
- *Dr. Strohmeyer's top priority when treating patients is health* and therefore recommends the best treatment for each individual. With all of the products and technology available, it is now possible to offer some restorative procedures with aesthetic options, such as composites vs. amalgams and porcelain vs. gold. There's always an additional cost for aesthetics. In regards to the materials placed for basic and major restorations, Dr. Strohmeyer will usually propose the esthetic material, which includes Composite for fillings and Full Porcelain for crowns. In some instances, the doctor may propose a n alloy filling material or a metal crown if he feels it will achieve a healthier, longer lasting result for the restoration. We will always discuss treatment before the procedures and are available to answer any questions that arise. If the lowest costs are truly a priority and aesthics are not a concern, please make the doctor or treatment plan coordinator aware of this preference. Also, if aesthetics are a high priority, even though costs may be higher, please inform the doctor or treatment plan coordinator of this preference. Lastly, an estimate for treatment and/or a cost comparison of the two options are always available upon request.

I have read your Financial Policy. I understand and agree with this policy

Print Name	Signature	Date

10-22-2012

Matthew F. Strohmeyer, D.D.S., L.L.C.

HIPAA Authorized Consent to Release Information

Patient's Name: _____

Patient's Date of Birth: _____

Please place a checkmark by your preference:

YES ☐ NO ☐	You may leave messages at my home or cell
YES ☐ NO ☐	You may send a text message to my cell (cell phone carrier text messaging fees/rates apply
YES ☐ NO ☐	You may leave message on my voice mail at work
YES ☐ NO ☐	You may send e-mail to my e-mail address

I understand that it is my responsibility to provide written authorization to Dr. Matthew Strohmeyer in order to release any medical information regarding my care. You can change these above preferences by requesting a new form at any time.

I hereby authorize Matthew F. Strohmeyer, D.D.S. to release medical information to the following: (i.e.- spouse, significant other, parent):

_____ _____

(Please Print Each Authorized Person's First and Last Name)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices for all
(Print Name)
who are in my household or under my insurance.

_____ _____

(Signature) (Date)

GENERAL EDUCATION PHOTO RELEASE

Explanation

In addition to the full series of x-rays we take on every patient, we are now taking clinical photos as well. In our continual effort to provide the most comprehensive and highest quality dental care, photos will now be a part of every patient's record. The photos will be used for diagnosis, treatment planning, communicating with our labs and with you (the patient). The purpose of this photo release form is that, in the event, one of your photos would be appropriate for educational purposes (ie: website, office displays, Dr. Strohmeyer discussing cases with colleagues, etc.), you give permission for such uses. All photographs, dental images, and radiographs displayed for in-office displays and on the website will be kept anonymous.

Patient's Name: _____

Patient's Date of Birth: _____

For valuable consideration, which I hereby acknowledge, I herby grant to Dr. Matthew F. Strohmeyer and/or his assignees, the absolute and irrevocable right and permission, with respect to the photographs, dental images, and radiographs taken of me, or in which I may be included with others; to use, re-use and/or publish the same in whole or in part, individually, or in conjunction with other photographs, without limitation in perpetuity. **These photographs, dental images, and radiographs shall be used specifically and exclusively for the purpose of dental education or dental claim submission.** I hereby release and discharge Dr. Matthew F. Strohmeyer and/or his assignees from any and all claims and demands arising out of or in connection with the use of the photographs, dental images, or radiographs, including any and all claims for libel.

_____ _____

Patient Signature or Legal Guardian Date

10-22-2012

Matthew F. Strohmeyer, D.D.S., L.L.C.

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS: The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside and outside of our office for these purposes without any special permission. You may send a written request to our office if you wish that we request special permission in a particular case.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION: In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are: when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices; disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws; disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies; disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else; disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations; uses or disclosures for health related research; uses and disclosures to prevent a serious threat to health or safety; uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service; disclosures of de-identified information; disclosures relating to worker's compensation programs; disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information. Unless you object, we may also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS: We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES: We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office.

ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, please send a written request to the office.

ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office.

ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office.

request a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office.

request additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you received one electronically or on paper already. If you want additional paper copies, send a written request to the office.

OUR NOTICE OF PRIVACY PRACTICES: By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS: If you think that we have not properly respected the privacy of your health information, you are free to send a complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to send a complaint to us, please send a written complaint to the office. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION: If you want more information about our privacy practices, call or visit the office.