**Michele Leone-Renne, D.D.S.**

83 S. Bedford Rd Mt. Kisco, NY 10549 2001 Palmer Avenue, Ste. 102 Larchmont, NY 10538

 914-218-3490 914-341-1941

**PATIENT REGISTRATION**

PLEASE PRINT

 Sex: ☐M ☐F Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Last Name First Name Initial Preferred Name

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

 City State Zip

Marital Status: □ Married □ Widowed □ Single □ Divorced □ Partnered for \_\_\_\_\_\_\_\_ years.

Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact (please check) ☐ Home☐ Cell ☐ Email Soc. Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 City State Zip

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Identification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # / Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Responsible for Account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address **(if different from patient**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is patient covered by additional insurance?** ☐ Yes ☐ No If yes, please list:

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Identification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # / Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Responsible for Account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (**if different from patient**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment and Release**

I, undersigned, have insurance and assign directly to Dr. Michele Leone-Renne all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minor/Child Consent**

I, being the parent of guardian do a hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Agreement**

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the reason for your visit today? \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Last Dental Visit**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Dental Cleaning**\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Full Mouth X-rays**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are any of your teeth sensitive to? ￼**

□ Hot or cold? □ Sweets? □ Biting or chewing? Have you noticed any mouth odors or bad tastes? □Yes □No

**Do you: ￼**

Clench or grind your teeth while awake or asleep? □Yes □No Bite your lips or cheeks regularly? □Yes □No

Have tired jaws, especially in the morning? □Yes □No Smoke/chew tobacco or use other tobacco products? □Yes □No

**Have you ever had?**

Orthodontic treatment? □Yes □No Oral Surgery? □Yes □No Periodontal treatment □Yes □No

Have you experienced: Clicking or popping of the jaw? □Yes □No Pain? (Joint, ear, side of the face) □Yes □N

Difficulty in chewing on either side of the mouth □Yes □No Do you have a bite plate or mouth guard? □Yes □No

Any severe injury to the mouth or head? If so, please describe, including cause\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your teeth’s appearance? □Yes □No If No, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have, or have you had, any of the following? (Check all that apply)**

□ AIDS/HIV Positive □Cancer □ Kidney Problems □ Low Blood Pressure □ Swollen Neck Glands

□ Alzheimer’s disease □ Chemotherapy □ Leukemia □ Mitral Valve Prolapse □ Stomach/Intestinal Disease

□ Anaphylaxis □ Circulatory Problems □ Hepatitis A □ Nervous Problems □ Stroke

 □ Anemia □ Cold Sores/Fever Blister □ Hepatitis B □ Psychiatric Care □Thyroid Disease

□ Angina □ Cortisone Medications □ Hepatitis C □ Radiation Treatment □ Ulcers

□ Arthritis/Gout □ Liver Disease □ Heart Pacemaker □ Recent Weight Loss □ Lung disease

□ Artificial heart value/joint □ Diabetes □ Heart Murmur □ Respiratory Disease □ Tuberculosis

□ Back Problems □ Drug Addiction □ Herpes □ Rheumatic Fever

□ Blood Disease □ Epilepsy/Seizures □ High Blood Pressure □ Sinus Trouble

□ Bruise easily □ Excessive bleeding □ Hypoglycemia □ Scarlet Fever

**Are you allergic to any of the following?**

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Women):** Pregnant/Trying to get pregnant? □Yes □No Taking oral contraceptives? □Yes □No Nursing? □Yes □No

Are you taking medication currently? □Yes □No If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of surgery? □Yes □No When/Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else we should know about your medical history? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Have you ever had **BOTOX** for treatment of migraines, grinding of teeth, or for cosmetic reasons? □Yes □No

If yes, when was your last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature of Patient, Parent or Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_

**Financial Agreement**

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment is considered a part of your treatment. The following is a statement about your financial policy. Prior to any treatment and to avoid any misunderstanding, we ask that you read, agree to and sign below.

**ADULT PATIENTS:**

The adult accompanying a minor and the parents (or guardian) are responsible for full payment. For unaccompanied minors, non-emergency treatments will be denied unless charges have been preauthorized to an approved credit plan: VISA, MC, AMEX, DISCOVER, and/or CASH at the time of services.

**PAYMENT:**

* We offer 10% **senior courtesy** for payment in full (excluding coupons and discounted insurance plans).
* A 10% courtesy may be offered on extended treatment plans if you pay for the services in advance with cash.
* Payment by appointment allows you to spread the payments out according to the treatment plan.

If you default on any payments, a 3% monthly finance charge will be incurred and after 60 days (about 2 months) of non-payment, a collection agency will be utilized to collect the debt.

**INSURANCE:**

If we are a participating provider, you are responsible for the full amount of services, whether the insurance company makes any payment on your claim. Any dispute over the amount paid or charges allowed is between you and your insurance company.

**\*Copayments and/or deductibles are to be paid at the time of your visit.**

Your dental plan is a contract between you and your insurance company. We are not a party to that contract. You can seek reimbursement directly from your carrier. We will, as a courtesy, submit insurance paperwork and if the insurance company needs any further information, we will be happy to provide that information.

Thank you for your understanding. I have read, understand, and agree with the above.

**Patient/Guardian/Responsible party** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **No Show / Cancellation Policy**

If it is necessary for you to cancel your scheduled appointment, we ask that you call by 10am two (2) business days in advance. Appointments are in high demand, and your early cancellation will give another patient the opportunity to access timely medical care.

**How to Cancel Your Appointment:**

To cancel a scheduled appointment, please call Office – If you do not reach the office, please leave a detailed message.

**Late Cancellations**

Late cancellations will be considered a “no show.”

**No Show Policy**

A “no-show” is someone who misses an appointment without cancelling it by 10am two (2) business days in advance.

**No-Show/Late Cancellation Fees**

Any dental appointment that is broken with late notice will result in a fee of **$95.00**/hour scheduled.

The office reserves the right not to reschedule your appointment until any cancellation/no show fees are paid in full.

Please note that if you are running late for your scheduled appointment, you should call to alert the office. While we will do our best to accommodate late patients, we may have to reschedule your appointment based on availability.

**Patient/Guardian/Responsible party** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_This agreement was entered on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

I hereby give my consent for Dr. Michele Leone-Renne to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO) (Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Michele Leone-Renne reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer.

With this consent, the office of Dr. Michele Leone-Renne may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of Dr. Michele Leone-Renne may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and material related to my clinical care if it is marked Personal and Confidential.

With this consent, the office of Dr. Michele Leone-Renne may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and material pertaining to my clinical care.

I have the right to request that Dr. Michele Leone-Renne restrict how she uses or discloses my PHI to carry out my TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the office of Dr. Michele Leone-Renne to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Michele Leone-Renne may decline to provide treatment to me.

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

Name of Patient

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

**Signature of Patient or Legal Guardian**

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

Date

**Michele Leone-Renne, D.D.S.**

**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**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in this Notice while it is in effect. This NOTICE takes effect April 14th, 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 such changes. We reserve the right to make the changes in our privacy practices and the added 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 meaningful 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 healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with widespread 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.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we believe that you are a victim of abuse, neglect, domestic violence, or a victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**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 of protected health information of inmate or patient under certain circumstances.

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

**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 do so, (you must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you for each page, for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will prepare a summary or an explanation of your health information for a fee, contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

**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, we will abide by our agreement (except in an emergency).

**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.) Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

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